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ROYAL COMMISSION ON MATTERS OF HEALTH AND SAFETY  
ARISING FROM THE USE OF ASBESTOS IN ONTARIO

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CHAIRMAN: J. STEFAN DUPRE, Ph.D.

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COMMISSIONERS: FRASER J. MUSTARD, M.D.

ROBERT UFFEN, Ph.D., P.Eng., F.R.S.C.

15

COUNSEL: JOHN I. LASKIN, LL.B.

APPEARANCES:

20 Mr. N. McCombie Injured Workers Consultants  
Miss L. Jolley Ontario Federation of Labour  
Mr. Cauchi

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180 Dundas Street  
Toronto, Ontario  
Thursday,  
July 15, 1982

VOLUME 50

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ROYAL COMMISSION ON MATTERS OF HEALTH AND SAFETY

ARISING FROM THE USE OF ASBESTOS IN ONTARIO

VOLUME 50

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THE FURTHER PROCEEDINGS IN THIS INQUIRY  
RESUMED PURSUANT TO ADJOURNMENT

APPEARANCES AS HERETOFORE NOTED

15

DR. DUPRE: May we come to order.

This morning the Commission warmly welcomes Dr. Charles Stewart of the medical services division of the Workmen's Compensation Board.

20

Dr. Stewart, may I ask you, please, to come forward and be sworn?

DR. CHARLES STEWART, SWORN

25

MR. MCCOMBIE: Mr. Chairman, I wonder if I might, before we begin...my understanding yesterday was that we would be adjourning at 5:45, and I did have a considerable number of questions for Mr. John McDonald, and I'm wondering if he is going to be called back in the near future.

30

DR. DUPRE: Well, if you feel you have a number of questions that you must pose to him, and that can't be answered, say, by Mr. McDonald, by the other Mr. McDonald when he comes, or by some of the medical services people, we will call him back.

MR. MCCOMBIE: I would very much appreciate that.



DR. DUPRE: I regret your absence yesterday, Mr. McCombie, because frankly I would have let the hearing run a little longer.

MR. MCCOMBIE: I see. Well, perhaps it was a misunderstanding on my part, but I did have a considerable amount of time, which is why I deferred my questions yesterday.

DR. DUPRE: Oh, well, that being the case, if you have a considerable number of questions, we will impose on Mr. John McDonald's good will to come back some time either this week or early next, and you will try to set that up, Mr. Laskin?

MR. LASKIN: I'll arrange that, Mr. Chairman.

DR. DUPRE: Thank you.

MR. MCCOMBIE: Thank you, Mr. Chairman.

EXAMINATION-IN-CHIEF BY MR. LASKIN

Q. Dr. Stewart, can you, for the record, tell us your present position with the Workmen's Compensation Board?

A. I hold the position as chest disease consultant to the Workmen's Compensation Board.

Q. How long have you held that position?

A. Since June of 1968. The title was somewhat different from 1968 to 1974, when there was a reorganization, but in essence it's the same responsibility.

Q. How long have you been employed by the Workmen's Compensation Board?

A. Since December, 1967.

Q. Did you hold some position very briefly before you became chest disease consultant?

A. I spent six months as a section medical officer in the Board, and attached to various divisions of the Board briefly, to learn the organization before I took on the position of chest disease consultant.



Q. Can you tell us very briefly your professional education and professional qualifications?

5 A. Yes. I graduated from McGill in 1959. I spent two years in Montreal hospitals in internship and residency.

I then went from Montreal to Elliott Lake, in 1961, the summer of 1961, and there I engaged in a general clinical practice with another McGill graduate, doing a lot of industrial work, compensation work, and it was there that I developed an 10 interest in chest and worked very closely with the physician in charge of the miners' chest station in Elliott Lake, almost from the start, and my interest in chest and my education took part, took place, to a substantial degree, in Elliott Lake.

15 As you know, Elliott Lake eventually produced a fair amount of chest disease, and the physician in charge of the station was a very knowledgeable clinician in tuberculosis and in silicosis, and it was around 1965 that I became very interested in the compensation part - particularly in chest - from my association with this physician, at the same time that I was doing my regular work.

20 I made overtures to the Board I would think at least 1965, that someday I would like to be attached and devote my time in this field.

25 My education was fairly...you must understand that silicosis was developing slowly in Elliott Lake at that time, and I had an opportunity to see it develop, to see the changes in serial films that were available, as well as in Sudbury. I did a fair amount of work in Sudbury at the Sudbury chest station.

30 This was background to my eventually coming to the Board. I came to the Board specifically to work in chest. It was understood when I came that I would. I did not come to the Board as a medical officer, general medical officer. I made it clear that I would not come to the Board under those circumstances, and



A. (cont'd.) the Board accepted me.

I had my probationary period and I took over the role  
5 of chest disease consultant in 1968, from my predecessor, who  
retired in June of that year.

10 Since that time I have been responsible for the  
processing and the disposition of all claims relating to  
pneumoconioses, all claims relating to occupational tuberculosis,  
all claims relating to respiratory cancers and the cancers  
associated with asbestos.

I have been the principal liaison with the  
Silicosis Referee Board, the advisory committee on occupational  
lung diseases, since I came to the Board in 1968, and was the  
middleman, as it were, between the Board and the committee.

15 I have also been responsible for the estimation of  
disability, pulmonary disability, in all claims other than those  
associated with the dust diseases.

Q. I just want to understand that. All claims  
other than those associated with the dust diseases?

20 A. All pulmonary claims. A claim involving  
asthma, a claim involving chest trauma that results in some  
disability, some residual disability. It is my responsibility  
to provide a rating for the Board, in the same way as it is the  
responsibility of the advisory committee to provide a rating for  
the pneumoconioses.

25 Q. Do we find you on the organization chart,  
located within the medical services division?

A. Yes. I report directly to the medical director.

Q. Dr. McCracken?

A. No. Dr. Dowd.

Q. Dr. Dowd?

30 A. Right.

Q. Dr. Dyer is also in the medical services division?



A. Yes. He works with me.

Q. Can you, in ballpark terms, just tell us  
5 approximately what your caseload is annually? What number of claims are you responsible for processing, given the description that you just told us?

A. I really...I know there are figures. I simply don't know. Enough to keep me very busy, believe me.

10 Q. All right. Can we just trace for a moment more specifically your involvement in the asbestos-related claims, and can we first of all deal with the claims for asbestosis, and do I take it that those claims, while some or many of them may ultimately find their way to the advisory committee, at least at some stage, all go through you?

15 A. Or Dr. Dyer. He may process most of the claims initially. I may see some, but Dr. Dyer, I believe, processes most of them. But I can answer any questions associated with the...

Q. Do you a particular claim from a claims adjudicator?

20 A. Yes. We will be sent a completed file with the minimal documentation in it, and we will be asked generally whether this claim should be listed for the advisory committee, whether it seems to have merit, and we will opine as to whether we feel it should be listed with the committee.

25 Q. I take it, then, in order that a claim be accepted for benefits, it must route ultimately to the advisory committee?

A. Yes, indeed.

Q. I also take it that there are some claims which you yourself, or Dr. Dyer, determine are not worthy of being passed on to the advisory committee?

30 A. Yes, indeed.

Q. Can you help us as to what criteria you employ



Q. (cont'd.) in determining whether or not to send a particular claim for asbestosis on to the advisory committee?

A. We want to see some evidence of...some x-ray evidence at least, on the record. We want to see possibly some evidence of pulmonary function deficit. We want to see, of course, some requisite exposure...some exposure that would account, that might account for an asbestosis change.

If I can address myself to your question in this way, we...perhaps this is the best way to do it...we looked at forty claims that were rejected at our level, and not sent to the advisory committee because of our advice to the claims department. Of those claims...

Q. Just so I get that straight, are these asbestosis claims?

A. Yes. Asbestos claims - claims for asbestosis.

Q. Was this a random sampling?

A. A random sample of the rejected claims, and I am referring to the claims that have been mentioned by Professor Barth, in which he has perceived that we have rejected a fair number of claims based on a single form.

When I read that, I felt that this was not accurate. We simply do not do that.

What we do require and what we look for is the x-ray report from the chest disease service of the Ministry of Labour, and by far the greatest number...most of these claims will be from individuals who are surveyed by the chest disease service of the Ministry of Labour - they are part of Dr. Vingilis's survey and we found in our forty claims that twenty-seven of those claims had clear, unequivocal reports from the chest service, the surveillance program. We found that a number of others had an x-ray report plus a consultation report, possibly from a radiologist. Other of those forty had



A. (cont'd.) tissue reports or a report from a respirologist.

5 We found no claims that were for asbestosis that were rejected solely on the form eight.

Now you must remember, the form eight might contain the details of the report from the chest disease service, and if there was simply no indication from the report from the chest disease service that there were any changes that were compatible with asbestosis, we would not send that to the committee. So the primary, the majority of those cases which we rejected, had reports from the chest disease service. They either had them enclosed with the form eight, or we had them in our files. We do get copies of the chest disease service surveillance reports. We have thousands of them, and we can go to these reports and look up a name to see if that man has been seen recently by the chest disease service.

Q. So that even if the particular claimant, in putting a claim forward, did not himself arrange to have the chest disease service x-ray get to you, you have your own resources to command...

20 A. We have them.

Q. You have all of them?

25 A. Well, let's say that we might not have all of them. We have the copies of most of the reports done on individuals who have been in recognized exposure. We don't get copies of all x-ray reports that are done by the chest disease service in the surveillance work, but we do get the asbestos.

30 Q. Can we step back just a minute so that we are clear, and it might help us if you can tell us what information gets to you in respect of an asbestosis claim, and how it gets there.

What is all of the information you have when you



5 Q. (cont'd.) are making this determination as to whether to send the matter on to the advisory committee or to, I take it, reject the claim at that stage?

A. We will have an idea of the type of exposure or the length of exposure, the duration of exposure.

Q. Where do you get that information from?

10 A. That will be either from an investigation report, from our own investigators who have been sent out, it may be from the company itself that provides a detailed...a detailed or not so detailed report on the exposure...or we may on occasion ask the occupational health branch to aid us.

15 We will try to have this information on file before we dispose of that claim, before we send it to the advisory committee or before we elect not to send it.

MR. LASKIN: Mr. Chairman?

DR. DUPRE: It's just, I guess, that I need to go just a little bit more slowly, Dr. Stewart, if we may.

20 I want to begin with what you said a little bit earlier in your testimony, a while back. You become involved when the claims adjudicator sends you a file, is that correct?

THE WITNESS: Yes, sir.

25 DR. DUPRE: Now, when you said that, the very next words that you said, after saying that the claims adjudicator sends you a file, was that you were saying that he is asking if a claim should be listed for the ACOCD.

THE WITNESS: Yes, you may do that.

30 DR. DUPRE: Oh, the adjudicator himself may ask you to...whether or not to route it to the ACOCD, as opposed to simply asking you for a medical opinion which it is your business to get?

THE WITNESS: Well, they are one and the same.



5 THE WITNESS: (cont'd.) It's understood that...it's always understood in these claims that if we feel it has merit, it will go to the committee...whether they ask us directly on the file or not, it's the same thing. I can't remember in every single case whether the claims officer actually said, 'should we list this with the committee'. In most cases he does, he or she does, but the intent is clear that when it comes to us it is to be either rejected or sent to the committee. There is no other way to deal  
10 with that claim, and they want our opinion as to what to do.

DR. DUPRE: Okay. Let's take it then that from time to time, the way they formulate a question to you may be somewhat different, but they want an opinion from you as to what to do?

15 THE WITNESS: Yes.

DR. DUPRE: Now, if I can proceed one more little step. Since there is a file, there is presumably something within the file.

THE WITNESS: Yes.

20 DR. DUPRE: Now, within the file would be some of the forms?

THE WITNESS: Yes, all the forms - the requisite forms, the form eight; there may be additional information attached to the form eight. It will vary. Not all claims are the same, contain the same information.

25 DR. DUPRE: Now as a general rule, in addition to the form...now first of all let me ask you this...if there is a form seven S, which is the employer form, that automatically gives a record in the file...

THE WITNESS: Yes.

30 DR. DUPRE: ...of an employer in whose employ the individual might have been exposed to the hazardous substance in question.



THE WITNESS: Or several employers, yes.

DR. DUPRE: Okay. So the file at least then has  
5 established for you, the claims adjudicator normally will have  
established for you the occupational exposure and the length of  
time in which the individual was employed?

THE WITNESS: Yes. Hopefully some accurate  
estimation of that.

DR. DUPRE: Now, you mentioned at this point that  
10 one of the things that you look for is for some x-ray evidence?

THE WITNESS Yes.

DR. DUPRE: Would the claims adjudicator normally  
have included x-ray evidence in the file?

THE WITNESS: Yes. It may be attached to any one  
15 of the forms that he received, from possibly the doctor, or even  
possibly the claimant himself. But it would be usually from  
the doctor, attached to the form eight.

DR. UFFEN: Which doctor? His private physician  
or a company doctor, or...

THE WITNESS: The physician who signed the form  
20 eight, who actually submitted the form.

DR. UFFEN: But that could be a company doctor, or  
would it be his family physician?

THE WITNESS: Rarely a company doctor. Mostly a  
family physician.

DR. DUPRE: Now, how frequently do you have a  
25 situation where the x-ray evidence that is attached by the  
individual's physician to the form eight is an x-ray that was  
taken by the Ministry of Labour chest survey, that was sent to  
the...

THE WITNESS: Yes. Of the forty sample we did,  
30 twenty-seven had.



DR. DUPRE: Had that kind of x-ray?

THE WITNESS: Had the actual x-ray report.

5 DR. DUPRE: Okay. And others would have the x-rays  
that came from where, if not the MOL? Just from...

THE WITNESS: Possibly a report from a hospital  
radiologist, possibly...occasionally from a respirologist,  
occasionally from death records, from the death certificate.

10 DR. DUPRE: Now, I think I've gotten straight at  
this point that the file has given you, in most instances, the  
record of exposure out of a form seven S - the adjudicator got  
that in there for you; the file has given you the kind of x-ray  
evidence that you have just discussed. Now at this point, when  
you were engaged in dialogue with Mr. Laskin, you said that you  
also, when you are examining the file, looked for some evidence  
15 of pulmonary function deficiency?

THE WITNESS: Yes. If it's there.

DR. DUPRE: If it's there?

20 THE WITNESS: If it's there. And it usually  
is when the report from the chest disease service is there,  
because they do pulmonary function studies, routine pulmonary  
function studies, of a minor nature - vital capacity and FEV 1 -  
that material is frequently appended to the x-ray report, from  
the chest disease service. And it is usually...it is usually  
set down in records that we have, that we store, copies of their  
reports.

25 But it may not necessarily be on the file, but  
it generally is.

Our principal concern, I think, with these files,  
these early claims, is that there must be some x-ray evidence,  
and we place great strength on the reports from the chest disease  
service.

30 MR. LASKIN: Q. Can I just explore that for a moment?



Q. (cont'd.) Does the report that you get from the x-ray service, does it, in addition to just having the x-ray, does it have a reading?

A. Yes. It has a diagnosis and it will usually be fairly firm.

Q. Is the diagnosis based on the ILO UC classification?

A. No. There is no rating classification.  
The diagnosis is there - no evidence of asbestos dust effects, no evidence of asbestosis - something, some statement to that effect that is clear - no change since last x-ray, no evidence of asbestosis or dust effects.

Q. When Dr. Vingilis was here, he told us that he had his own internal rating system which, as I recall his evidence, went from numbers one to six, and each particular number had a specific description attached to it.

A. This is the Ontario system that has been used since 1936 in Ontario.

Q. You get that?

A. Yes. Well, put it this way: They are starting to use the ILO system in the Ministry of Labour, but up to at least 1980, the Ontario system was used. But it's not a critical thing in rating the asbestos claims.

The Ontario system was developed primarily for silicosis, and it's not really applicable after a three rating is reached, and generally speaking one would like to label the pre-asbestosis stage, if you will, as pre-asbestosis or asbestos fiber dust effect, rather than the equivalent code four rating for silicosis, the pre-silicosis.

I know it's complex, but...

Q. No one has ever educated us on what particular numbers mean, and that may be part of our difficulty.



Q. (cont'd.) Would you like...

DR. DUPRE: Dr. Mustard, did you want to ask a  
5 question at this point that may lead to our education in this  
domain?

DR. MUSTARD: I just wondered if we could digress  
for a moment and ask you to explain to us what you mean by the  
use of the term 'pre-asbestosis'.

THE WITNESS: Could I start out by saying, Dr.  
10 Mustard, that since 1930, we have had an x-ray classification in  
the mining sphere, of pre-silicosis, so-called. We have  
developed an enormous statistical data system based on code four  
or pre-asbestosis, and code five rating or...I'm sorry...silicosis,  
or code five rating...code four is pre-silicosis; code five is  
silicosis.  
15

I will explain this system to you.

So this concept of incipient pneumoconiosis,  
incipient silicosis, is one in which is incorporated the premise  
that there is an area between normality and abnormality in the  
chest x-ray. It is an x-ray concept that is not so abnormal  
20 as to be called silicosis, but is not so normal that be called  
normal. It is a halfway point in the spectrum of change that  
results in long-term exposure to mineral dust. It doesn't happen  
overnight, it's a gradual thing.

You have to ask the question 'when do you diagnose  
silicosis'? At what stage do you diagnose silicosis?  
25

I'll use silicosis as an example, before I get  
to asbestosis.

So the Ontario Board has used the South African  
system since 1936, in which this pre-silicosis stage is  
recognized...an incipient stage of silicosis. It's an x-ray  
classification purely, and depends on a characteristic pattern  
30 that can be seen or perceived at least by a fairly experienced



THE WITNESS: (cont'd.) reader, and which has been used by many physicians attached to the chest stations throughout Ontario since 1929, when the chest stations for the surveillance of miners were first established under the Mining Act.

The Ontario system developed out of the South African classification that started off with codes. A code one was a perfectly normal chest. Code two - a slight increase in the markings that you would see in the chest x-ray. Code three - a moderate increase in the linear markings in a chest x-ray. Code four - a slight disruption of the pattern, with a beginning lace-like or net-like change...they called it arobrization, where there was some obscuring of the normal pattern, possibly also including some very small pinpoint, pinhead-size inclusions that were not recognized as nodules.

The next stage would be a stage where you could see frank nodulation - nodulation that was visible, possibly one to three...around two or three millimeters in diameter - scattered in the upper lung fields. This is when you reached your code five, which is silicosis. That's when you could say, I can just barely diagnose silicosis.

So we have the spectrum of change. Based on this classification we have developed a very large statistical data bank in which various cohort analyses have been done over the years involving different age groups, starting in different periods in Ontario and being followed, and resulting in prevalence of fours, prevalence of fives, incidence of silicosis per thousand manyears of exposure, etc., etc.

We published at least two fairly large reports on the statistical analysis using this system of coding. It's an x-ray code.

Now, when we were asked to consider the coding



THE WITNESS: (cont'd.) of asbestos, it's clear  
that up to code three it's probably fairly easy, but after that  
it's not as easy - although if you look at your serial films...and  
once again, this depends largely on the analysis of serial films...  
in a particular industry, say like Johns-Manville, or in any other  
industry in which the changes due to the asbestos inhalation are  
somewhat characteristic of that industry, while I'm not expert  
in this field I do understand that asbestotic changes, changes  
due to asbestos, and the asbestos dust effects, have a slightly  
different pattern depending on the industry - whether it's textile,  
whether it's asbestos cement, or whether it's mining - there is  
a characteristic pattern. One is more coarse than the other, or...  
so that if you are going to develop the concept of incipient  
asbestosis, it has to be done within the context of the industry  
which you are interested in. It's not really very easy, as you  
can, say in silicosis, but even then it's not particularly easy  
either, but it's more applicable there, to develop a general rule  
that you can apply to all industries.

The concept of a pre-silicosis can generally  
apply to most of the mining camps in Ontario, because even though  
many mining camps have a characteristic pattern of silicosis  
that is distinguishable..the pattern of silicosis that develops  
in the Elliott Lake camp is quite distinguishable from that  
developing in the gold mines, early on at least. It is certainly  
distinguishable from the foundries.

So while silicosis is characterized by nodulation,  
the pattern is slightly different depending on the industry  
concerned.

So pre-asbestosis, we were asked to develop this  
concept more because of the Elliott Lake special program than  
anything else.

DR. UFFEN: Asked by whom?



THE WITNESS: We were asked by our Board.

In developing the program for Johns-Manville, for  
5 the asbestos industry, we had to - from scratch - develop or  
define pre-asbestosis, because it had not been done before. It  
had not been done on a structured basis before, because we have  
no statistical system and haven't developed any statistics in the  
asbestos industry as we have done for the mines. There is a total  
lack of statistics, and it was simply because the mining  
10 industry in the fifties decided that they wished to look at their  
industry that we developed this statistical system, and we  
developed a nominal role that probably embraces now sixty thousand  
miners with hundreds of thousands of records associated with it.

Am I getting there? I don't know whether...

15 DR. MUSTARD: No, you've gotten there. Let me  
ask you some questions about this...

DR. DUPRE :Just so that I can be sure that he has  
gotten there, Dr. Mustard...when you refer to having been asked  
to define the pre-asbestotic condition, are you referring to when  
you were asked to set up a guideline for asbestos fiber dust  
20 effects?

THE WITNESS: We weren't asked specifically to  
develop that. That was...we were asked to take the Johns-Manville...  
the Elliott Lake program, the special program, and apply it to  
Johns-Manville.

25 In order to do so, we had to develop the pre-asbestosis  
concept.

DR. DUPRE: The pre-asbestosis concept being what  
you wound up...

THE WITNESS: Yes, sir.

30 DR. DUPRE: ...writing down as the asbestos fiber  
dust effect guideline?

THE WITNESS: Right.



DR. DUPRE: Thank you.

5 DR. MUSTARD: Let me ask you a few other questions related to this very difficult subject.

As the quality of x-ray imaging has improved, has that had any impact at the point in time of the process when you define someone as having asbestosis as opposed to pre-asbestosis? Am I making myself clear?

10 In other words, you take the fibers in and as the changes in the lung progress, you reach a point at which you can pick them up on x-ray examination. As the sophistication of the imaging techniques improved, the possibility of earlier detection is increased.

15 Is there any impact of that...

15 THE WITNESS: I think that it's very relevant, of course. There is no doubt that the better your x-ray the more confident you will be of what you are trying to do. But insofar as our x-rays are concerned, or the x-rays held by the chest disease service, there hasn't been much change in the technique and the quality in the last ten years or so. In fact, some of the better x-rays in the mining industry were taken in 20 the fifties and sixties.

25 DR. MUSTARD: Okay. Let me take it in a slightly different context. Some of the other approaches to it, in our professional trade it's called imaging, are coming on the market, and some of them in the field in which I have some experience are very powerful. Let me pose a problem for you.

If I take coronary artery disease, the standard method for us to make a diagnosis of heart disease is, of course, when you come down with the symptoms that are caused by the underlying process.

30 You can use x-ray and imaging, certain invasive



DR. STEWART :(cont'd.) techniques, to show the state of the coronary arteries, as you know, and you can say that the person is likely to have a heart attack by looking at the condition of their arteries, but that imaging technique is not as sophisticated as some of the more fancy ones coming on, which use a totally different technique which will show very early changes in the vessels, in the coronary arteries, before you can show them with an x-ray technology.

THE WITNESS: Yes.

DR. MUSTARD: I guess the question that comes up to me in terms of the definition of pre-asbestosis which you are using, if that technology can be applied to the examination of a lung so that you can pick out the fibrotic changes before they can be picked up by the x-ray technology, would that mean, therefore, that you would have to shift the diagnosis of pre-asbestosis down to what that imaging technique is able to show?

THE WITNESS: If we were convinced that there was a significant difference in time between those two, whether there would be two, three or four or five years difference, I couldn't really say whether it would be useful in this particular context.

I haven't really given that thought. I haven't really thought of that, of altering our guidelines by virtue of a new technique. It would have to be given some thought.

DR. MUSTARD: Let me pose the dilemma it creates for me, and I'll explain to you what is in the back of my mind so that you can then respond with sort of everything up on the table, so to speak.

From the testimony we've heard, and indeed from some of my own experience, the process probably begins very early after the exposure, the changes that will take place and the stimulus to the fibroblasts to proliferate, etc., and the



DR. MUSTARD: (cont'd.) long process that goes on before it becomes technologically measurable through x-ray or produced clinical symptoms that, as a physician, you recognize. Therefore, one is caught in the biological process versus the clinical recognition. End of question.

My interpretation of what you said about pre-asbestosis, it's a technological definition, not based on the biological process itself, but based upon when you can detect those changes using an x-ray technology.

THE WITNESS: It's an x-ray technique, yes.

DR. MUSTARD: But that is the principle, and if I come along with a more sophisticated technology and can pick up these changes earlier, if I was applying that rule then I would have to use the term pre-asbestosis at an earlier stage in the history of it.

THE WITNESS: I would agree.

DR. MUSTARD: Okay. I think I've got the feel for it now. Thanks.

MR. LASKIN: Q. Just coming back to the information that you have, you have told us you will have...I see the Chairman...

DR. DUPRE: I just want to make sure, counsel, that you pursue the code numbers.

MR. LASKIN: Yes, I'm going to.

DR. DUPRE: Good, because silicosis was beautifully explained and...

MR. LASKIN: No, I'm going to.

DR. DUPRE: ..I can hardly wait for the next step.

MR. LASKIN: Q. We have the forms and we have x-ray evidence in, I take, most cases. Can you now give the explanation in the asbestosis field, in the asbestos field, which you so



Q. (cont'd.) articulately gave to us in the silicosis side?

A. I said that the chest disease service does not normally use code four to describe the changes in the chest x-ray that one would interpret as pre-asbestosis. They will... rather than coding them, they will describe them. They will describe changes that relate to the linear pattern in the lower lung field as being slightly increased, or slight interstitial change suggestive of mild fibrosis, slight blunting of the costophrenic angles. This will be the description in the chest x-ray. It won't be a code four, it will be an actual description of the changes, and the conclusion - asbestos fiber dust effect, possible, or early asbestosis.

Q. Is there in fact a code for asbestosis, lying behind the descriptions? I take it from Dr. Vingilis...

A. It can be used, if you wish. I don't see any reason why you can't use a code four for pre-asbestosis, as long as you understand the context in which it's being used, and that it's not as precise. But it's a method, it's a language, but it's better to describe what you are saying.

Q. I appreciate that. I think the difficulty we are having is that we heard some evidence from Dr. Vingilis where he mentioned the use of this code and the application of this code to asbestos, but we didn't get any elaboration as to what the numbers meant and what was the description opposite the numbers, and as I listen to your evidence I thought you were describing the code as it applied to silica and silicosis...

A. Yes.

Q. ...and my question to you really is, if there is a comparable code applicable to asbestos, can you give us that description?

A. No, I cannot. There isn't a comparable code.



5 A. (cont'd.) It's okay up to the code three, the changes that are covered under the code three rating of silicosis can be applied to the asbestotic, or the asbestos.

DR. DUPRE: That's where I wanted to get in my very slow way, so that once again, a one would be perfectly normal.

THE WITNESS: Mmm-hmm. It's rarely used.

10 DR. DUPRE: A two would be a slight increase markings, a three would be moderate linear markings.

THE WITNESS: Yes, a moderate increase.

DR. DUPRE: Okay.

MR. LASKIN: Q. And when we get to four?

15 THE WITNESS: A. A four under the silicosis system is called arborization. In other words, the typical sort of tree-trunk pattern, without the leaves, that characterizes the pulmonary tree is somewhat obscured and distorted by a lacy change, a characteristic...it's hard for me to describe, I suppose, but it's definable and it's accompanied by little inclusions, pinhead inclusions, so it's recognizable and you don't really have to describe it if you are describing it in a miner. It's code 20 four. It's arborization.

Now, in the asbestos case, the changes are not quite the same, because first of all the changes in pre-asbestosis are in the lower lung fields and they are interstitial and linear, they are not nodular. The pattern is not altered in the same 25 way in these early changes, in the asbestos case.

So while there are some vague similarities between the code four as it applies to silicosis and the changes that apply to asbestosis, they are not really synonymous, and the South African system wasn't developed for that in the first place.

30 DR. UFFEN: You've put something to rest, because it may not be important. Is there a similar situation with respect



DR. UFFEN: (cont'd.) to lung damage from radiation, healthy particles or something like that, and could they be...what  
5 is in my mind is if there is, can there be any confusion between  
radiation and...

THE WITNESS: No, we have never used that. We have never used that system at all for...

DR. UFFEN: In the Elliott Lake case, where a man may be exposed to silica dust and the...

10 THE WITNESS: Oh, I see. I see what you mean.

DR. UFFEN: You used that as the stepping stone to the asbestos case?

15 THE WITNESS: No. We have never...it has never been recognized that radiation has influenced the development of silicosis, or the pattern.

DR. UFFEN: Or of asbestos?

THE WITNESS: Or of asbestos.

DR. UFFEN: There is no synergism going on?

20 THE WITNESS: It has been...there has been speculation on this, but simply there is no data that ever supported such an association.

So really, the pre-asbestosis stage should be described, rather than just coded as a four, because the South African system was not designed particularly for that.

MR. LASKIN: Q. And what you get is a description, not a number?

25 THE WITNESS: A. A description, yes. A description.

Q. Are there any cases which come forward to you, claims for asbestosis, which don't carry with them x-ray evidence?

A. Yes, but we will try to secure it, and we have on occasion secured the x-rays ourselves, to look at.

30 We will not deal with a claim unless we have some



A. (cont'd.) x-ray evidence.

Q. So I take it we can all be assured that no  
5 claim will be rejected without x-ray evidence?

A. Highly unlikely. Highly unlikely.

Q. But possible?

A. I would like to think that one couldn't slip  
through, but I think the chances are low. I suppose it's  
possible, but...

10 DR. UFFEN: Do you look at these x-rays, or do  
you accept the evaluation of the person who has submitted them  
to you? Sometimes it's a chest industrial expert, sometimes  
it's a physician or a hospital. Do you double-check on that?

15 THE WITNESS: We know...out of the forty cases  
of the sample, we saw two. We got x-rays on two occasions,  
ourselves. We accepted the evidence on twenty-seven of the x-rays  
that were submitted by the chest disease service.

MR. LASKIN: Q. So if Dr. Vingilis's service  
sends in x-ray evidence on a particular claimant, I take it your  
branch will, in effect, accept that evidence?

20 THE WITNESS: A. We will.

Q. All right. If the x-ray evidence is coming  
from another source, do you automatically accept the other source  
or do you do your own analysis or reading of the x-ray?

25 A. We may accept it and we may not. We may  
ask for the x-rays. I really can't tell you exactly. It depends  
on the case. It depends on the circumstances of the case, the  
feel for the case that we have. I'm afraid every case is different.

MR. LASKIN: Dr. Mustard?

DR. MUSTARD: Do you ever have a situation in which  
the x-ray evidence has been prepared by a group external to the  
30 chest service of the Ministry of Labour?

THE WITNESS: Yes.



5 DR. MUSTARD: It could be from the Ottawa General Hospital, or some place like that, and which the family physician submits?

THE WITNESS: Yes, we do.

DR. MUSTARD: Do you ever have that evidence in conflict with evidence from another source? That is, two different interpretations of chest x-rays?

10 THE WITNESS: I have never...I cannot remember...I can't remember such a situation. I have not seen all the claims which have been initially processed for asbestosis.

15 DR. MUSTARD: Let me pose a question, a theoretical question. How would you handle the following situation: You have a claim that has been submitted in which the x-ray evidence and the family physician evidence has come from a source such as a large community hospital. You also have evidence, say from the Ministry of Labour's chest service, of x-rays, and there is a conflict - the one says yes, there are changes, the other one says there are not changes.

20 THE WITNESS: That's possible.

25 DR. MUSTARD: How would you resolve the difference of opinion? Would you automatically accept the chest service's opinion over the other one?

THE WITNESS: We might in some instances, and we might not. I suppose it depends on the other evidence in the file.

25 We will look at the duration of exposure, the kind of exposure he has had, his age, and the likelihood that there will be changes that will be due to asbestos, and we will have to weight this evidence and decide. If there is any doubt, we will refer it. Generally we will refer it to the committee.

30 The claims officer has often asked us to do, and we have often done so despite the fact we have felt that it's not



THE WITNESS: (cont'd.) necessary.

5 DR. MUSTARD: And the committee would have on it people from the chest service who could be responsible for one part of the x-ray evidence...

THE WITNESS: Yes, yes.

10 MR. LASKIN: Q. Can I just...and I'm sorry to pursue this at length, Dr. Stewart, but can I just make certain about the twenty-seven cases that you referred to?

15 THE WITNESS: A. Right.

Q. There is a statement on page two point fourteen of Professor Barth's study, where he talks about what he calls the asymmetrical pattern of response by the Board's staff doctors, in the full paragraph on that page, and midway through the paragraph says:

"However, in twenty-seven claims of those sampled, the case was not forwarded on to the ACOCD, apparently because of a negative report on the eight S form."

20 A. Yes.

Q. Now, are those the same twenty-seven cases that we are talking about?

A. We don't know, but the eight S form may well have contained a report from the chest disease service.

25 Q. The eight S form is what, now?

A. The doctor's form.

Q. The claimant's own...it's at page two point three five of Professor Barth, and it is, I take it, the claimant's own physician's report?

A. Yes, right. Yes.

30 He may well send in, in fact, a copy of a letter received from the chest disease service...maybe.

DR. DUPRE: Can I take it, Dr. Stewart, that the



5 DR. DUPRE: (cont'd.) x-ray material that is in the file will normally just be appended to the eight S form, because I note that the eight S form asks the physician to fill in chest x-ray, where and when?

THE WITNESS: Yes.

DR. DUPRE: And presumably if he has ticked those things off, he is simply including...

10 THE WITNESS: Yes. Dr. Vingilis's name is frequently mentioned on that eight S form, or one of the names of the physicians at the chest disease service. On that...

DR. DUPRE: And indeed right on the form eight S, there is a box in which findings are to be written.

THE WITNESS: Yes.

15 DR. DUPRE: Then 'pneumoconiosis present, tuberculosis present' and a box in which presumably the reader's name will appear?

THE WITNESS: Yes.

20 I suppose it's technically possible that only an eight S form will be there, but as long as we have the information relating to the chest disease service report, that's what we want. That's what we would like to rely on, and even if it isn't there, we can go to our own records and probably will find this man's report.

25 MR. LASKIN: The impression at least I have from reading what Professor Barth said here was, that you and Dr. Dyer, in making a determination as to whether to send the matter on to the ACOCD, or to reject the matter, in situations where the claimant's own doctor had given a negative report chose to reject the matter and not send it on, and the impression at least I had from reading this was that you were relying on the claimant's physician, whether or not he had any particular skill or not in the diagnosis of a chest disease.



5 THE WITNESS: A. No, we don't. No. I don't remember a form eight S in which the family physician reported no evidence of the disease, because I presume that he is sending in a form because he feels that there may be some changes.

Q. So what you are essentially telling us is, you are looking for x-ray evidence?

A. Yes, definitely.

10 DR. UFFEN: The chest...Dr. Vingilis's chest...whatever it's called...if they send over a report that says 'no change', is that the end of it?

15 THE WITNESS: We will take that as not enough evidence to send to the committee. If the x-ray is reported and is described, it usually is 'no change in the parenchyma, no change in vital capacity, normal pulmonary function, normal FEV 1,' we will simply not send that claim to the advisory committee.

20 DR. UFFEN: There is a problem for people outside the system, like me, maybe built-in to my nature. The evidence comes from the chest division to an individual like you, who has to make a decision to send it to a committee, where the judge will be the person who sent the recommendation in the first place.

THE WITNESS: He is one of seven members of the committee.

25 DR. UFFEN: Later on I would like to come back...I don't think this is the appropriate time, about how the committee operates, what is a quorum, who is there, etc., because that will probably answer my question.

THE WITNESS: Can I just add something here, to explain?

DR. UFFEN: Yes.

30 THE WITNESS: Perhaps we should look at the number of claims that the committee itself rejects. In other words, the ones we send over.



5 THE WITNESS: (cont'd.) Professor Barth has said that between 1975 and 1980, a hundred and nine claims were processed by the Board that were never sent over to the committee.

But between 1975 and 1980, of the claims that we sent over, sixty-nine were rejected by the committee as showing no asbestosis.

10 So I'm saying that while we are rejecting a few, the advisory committee is still rejecting many of those that we send over. So if they were only rejecting one or two...but they are not. In 1978, they rejected nine new claims that we sent over. In 1979, they rejected thirteen. 1980, well, looks like sixteen.

15 In other words, every year they reject, on occasion, more than they accept. So I think we really feel that we are doing an initial screening that is not that harsh, because there is an awful lot going through that are themselves rejected by the committee of the whole.

I suppose I should point that out to you.

MR. LASKIN: Q. Why don't we go to Dr. Uffen's question...

20 DR. DUPRE: Just before we do, because that's the ACOCD route, let me dispose of one last thing. If your decision, Dr. Stewart, is not to forward to the ACOCD, and you report that back to the claims adjudicator, correct?

THE WITNESS: Correct.

25 DR. DUPRE: Now, the claims adjudicator at this juncture cannot deny the claim, as I understand it. He has to send it to the claims review branch.

THE WITNESS: Yes.

DR. DUPRE: Now, has the claims review branch ever asked you to reconsider?

30 THE WITNESS: I think they have, and I can quite conceive that we would, on their request, send it to the committee.



DR. DUPRE: Okay.

5 THE WITNESS: No question. We do not...if they have some particular concern, we will end up by all means, send it to the committee. Yes, very much so.

10 DR. DUPRE: That's an important thing for me to bear in mind, because that's a reminder that there is a check on the claims review branch, and if they find any reason to question your opinion, then you will route it to the ACOCD?

15 THE WITNESS: Yes. On occasion it has gone to the appeals adjudicator, and they have requested it. Not necessarily asbestos, other claims, and we have said yes.

DR. DUPRE: The general family...

20 DR. UFFEN: Just so I understand the Chairman's point, there aren't any medically-qualified people in the claims review branch, so they would be having to send to you a request for reconsideration of medical decisions, when they aren't medically qualified?

25 THE WITNESS: No, they may have some comment on the duration of exposure, or they may point out that the family doctor has strong views or something. Once again, it...

DR. UFFEN: They would review the whole file, including the various medical contributions that might have come - the type that Dr. Mustard mentioned earlier on?

THE WITNESS: They look at the whole file. They are not going to get into the business of who is correct.

25 DR. UFFEN: No, but they could recognize if there was a disagreement?

THE WITNESS: Yes. Oh, yes. Definitely. Very much so.

30 We certainly would not put up any fight if it were...if there was insistence.



DR. UFFEN: Then it's going back to this advisory committee, it can go this way up there and it keeps coming back to this advisory committee. Okay.

DR. DUPRE: Now, I guess we are ready for the advisory committee, counsel.

MR. LASKIN: Q. Just one last question. If...to follow the Chairman's point...if the claims review branch does want the matter reconsidered, does it have direct access to the advisory committee, or is the routing always through you or Dr. Dyer?

THE WITNESS: A. They will come back to us.

Q. All right. Then we get to the advisory committee, and just before we outline that can you just tell us what you send to the advisory committee?

A. We automatically send all claims that may relate to any mineral dust disease - silicosis, asbestosis, talcosis, hard-metal disease, methylene syenite pneumoconiosis, shaver's disease, bauxite pneumoconiosis - we will generally try to send them all these cases automatically.

Q. If it's a claim for asbestosis, what information do you send along to the committee?

A. We send everything we have on the claim. We send all the details we have of their exposure, including investigation report if we have it, if we've had to send out someone, because someone has worked for many different employers, we send copies of any consultation reports, any tissue reports that we may have on file - everything we have in the file, the committee gets.

Q. Do they get in the form in which you got it, or do they get in some summarized form?

A. Oh, no, no. Copies of everything. Copies of everything. We do not summarize anything for the committee.



Q. So everything that you got, they would get?

A. Yes.

DR. DUPRE: They get a copy of the entire file?

5 THE WITNESS: Absolutely, yes.

MR. LASKIN: Q. Superimposed on that, do they get  
any additional opinion from you?

THE WITNESS: A. No, never. Absolutely not. I  
do not put my opinion in. I ask for their opinion, or in effect  
we are asking for their opinion. I never intrude, and never have.

10 DR. UFFEN: Just in passing, would there be included  
any information from a previous claim, which may or may not be  
related to the one under consideration?

15 THE WITNESS: Yes. Some claimants have more than  
one claim going at once. It's possible, but...

DR. UFFEN: The example I have in mind - a young  
man has an accident and there is a claim relative to the accident,  
in your file somewhere.

Sometime later, up comes a claim related to chest.  
Do you go back into the old files?

20 THE WITNESS: I can't remember an occasion. I  
would like to think that, yes, we would be sharp enough to send  
this information to the committee if it existed. It's possible  
that we might get a claim in from a man who we wouldn't know had  
another claim. That has happened, and there is no assurances  
that he would necessarily...

25 DR. UFFEN: You would see...do I understand  
you correctly...you would see it as the proper thing to do, if  
you found there was a pre-existing claim, to include that  
information?

THE WITNESS: If it had some relation to the...

DR. UFFEN: And you would make that judgement?

30 THE WITNESS: Yes. If the man who was submitting



THE WITNESS: (cont'd.) a claim for asbestosis had  
a broken leg, I don't think I would - if that was the claim.

5 DR. UFFEN: But you make the judgement?

THE WITNESS: Yes.

DR. UFFEN: What I have in mind is, miners roam  
around a lot. There may be five years at Elliott Lake, and then  
ten years at Asbestos, Quebec, and maybe somewhere in South  
Africa for awhile, and it's not impossible that in such a case  
10 there could be an existing file for different circumstances in  
the different mining camps doing the different ore mineralogy.

15 THE WITNESS: Yes. Of course, in the case of a  
miner it's easy because we have his total exposure in the printout  
that we get, or a writeout, very easily. So there is no problem  
there. The advisory committee receives...but as far as...

15 DR. UFFEN: One final question. Does the claimant  
have access, or his representative have access, to those old  
files, too?

20 THE WITNESS: I suppose he would under the proper  
context. Dr. Uffen, you are getting into areas where I am a  
little bit shaky on terms of access, file access.

DR. UFFEN: You may be shaky. I'm ignorant.

THE WITNESS: I presume the whole file is  
available, once it reaches a certain appeal stage, and I  
presume...I'm shaky there.

25 MR. LASKIN: Q. What opinion are you asking the  
advisory committee to make on a particular claim for asbestosis?  
What specific questions are you asking to them when you send the  
file to them?

30 THE WITNESS: A. We have been sending files to  
the committee for fifty-five years, and when we send a claim to  
the committee for asbestos, they know what we want. They know  
that we want a diagnosis, and we want an estimate of the impairment



A. (cont'd.) or the disability that arises from that.

5 That is the sole consideration that they are given. We do not ask them anything more explicitly.

Q. And when you use the word impairment, because you said impairment or disability, and I just want to make sure we are all on the same wavelength, are we talking about impairment in the sense that Professor Barth used it - physical impairment, 10 a medical concept? Is that what you are looking for?

A. Yes. Impairment resulting in physical or functional disability.

DR. DUPRE: Just one question. This has to do with what is in that file that you are sending to the ACOCD.

15 You mentioned, Dr. Stewart, in your evidence, words to the effect that if we have needed an investigator's report, we have included the investigator's report or reports in the file.

20 The investigator's reports, as I understand them, would relate to exposure to the substance and for how long and with what employers. My question simply is this: You, yourself, or your particular branch, would not have requested those investigator's reports, would they? It would be the claims adjudicators?

THE WITNESS: Yes, the claims adjudicator...

25 DR. DUPRE: Would put them in the file?

THE WITNESS: Right, right.

DR. DUPRE: Okay. I just wanted to make sure that I had that straight.

30 THE WITNESS: The file...we hope and we expect that the file will be fairly complete before we receive it from the claims branch. Otherwise, we would have to send it back.

MR. LASKIN: Q. I take it, by the way, just before



5 Q. (cont'd.) again we get to the ACOCD, there are no cases of claims for asbestosis where you personally would conduct any physical examination of a claimant?

THE WITNESS: A. We never do. We will not...we never, under circumstances, bring the individual in, in initially disposing of the claim. We don't do it.

10 Q. Can you tell us first of all, with respect to the ACOCD, who are its current members, and can you tell us how long each of those members has been on the committee?

15 A. The chairman is Dr. Cecil Roerbeck. He, for twenty-five years or so, was head of the division of chest...now, chest diseases in the Ministry of Health. My terms may be a little inaccurate, but he was in charge of the provincial chest clinics for many years, and retired from the Ministry of Health a couple of years ago.

He came on the committee in 1961, as a member, and became chairman in 1976.

20 The next member, Dr. Vingilis. Dr. Vingilis was with the Ministry of Health for many years in the chest disease services, and was principally engaged in the screening of surface industries in Ontario - that included asbestos and quartz, and other industries that had some potential hazard.

He came on the committee in 1972.

25 Dr. Walter Mehle, presently is employed by the Ministry of Health as a...oh, I'm afraid it escapes me, his exact title...so I can't, I might as well not guess. He came on the committee in 1972.

Dr. Joseph Budlowski. He was also with the Ministry of Health, and laterally with the Ministry of Labour, for ten or more years, until he retired last year.

30 Dr. Jan Roos, R O O S. Dr. Roos came to be employed by the Ministry of Labour in 1974. He became a member of the



A. (cont'd.) committee in 1975.

Dr. Gray came on the committee in 1973.

5 Dr. David Muir came on the committee in 1978.

I think that's all.

DR. DUPRE: Seven members, is that correct? Now, do I take it from this, Dr. Ritchie (sic), that Professor Barth is in error when he reports that the advisory committee...this is on page four, two...that the advisory committee has only five members, and that the other individuals that are involved with it are consultants?

THE WITNESS: I included Dr. Muir. I include him as a consultant, with Dr. Gray.

DR. DUPRE: Sorry. You included both Dr. Muir and Dr. Gray in the seven, but actually you agree with Professor Barth's description, they are not members of the committee, they are consultants?

THE WITNESS: No, I consider them members of the committee.

DR. DUPRE: Oh, you consider them members? All right.

20 THE WITNESS: I think they always have been considered members. Dr. Ritchie is not...Dr. Ritchie would be a consultant in the sense that he doesn't sit with the committee. He is consultant to the committee, consultant to the Board, but since there is so much interaction between Dr. Ritchie and the committee and the Board, it is a de facto type of situation there, I think.

25 DR. MUSTARD: Could I ask a question about this?

It seems to me from the description, the discussion, you could structure a committee with ten people on it, and you could therefore draw those ten people from any jurisdiction. Is that right? There is no set rule as to where they should come from or what the total membership should be?



THE WITNESS: That is true. There is no set rule.

DR. MUSTARD: And if you wished to do that, you would simply draw the names up and have the Board approve them?

5 THE WITNESS: Yes.

DR. UFFEN: Is it your understanding that they are there in their professional capacity as experts on chest disease in one form or another, or that they are there partially representing their constituency? Like the department of health...

10 THE WITNESS: Oh, no, no. There is a definite separation and there is no interaction at all. They are purely to advise the Board. We have had no problems of overlapping or of conflicting interests. That has never arisen.

15 It has been, to me, a wonder how it has gone so well for so many years, and worked so well.

MR. LASKIN: Q. Is it there to advise you or to advise the Board?

20 THE WITNESS: A. The Board. They simply go through me as the liaison between the Board and the committee.

Q. You consider this committee advisory to the Board, rather than being advisory to you as one of the Board's physicians?

A. Oh, to the Board. They simply send their reports through me, presumably because these are medical reports and they would like to send them directly to a physician.

25 Q. I see. I think the analogy that we had before, and I think this was put by the Chairman and I hope I put his analogy accurately, to Dr. Vingilis, that the relationship the advisory committee had was the same kind of relationship that a general physician might have seeking the expert opinion of a specialist?

30 A. In actual fact, prior to 1976, all the reports were directed to the chief claims officer.



Q. Not even through you?

A. No.

5 Q. You've got to say 'no', for the record.

A. No.

DR. UFFEN: So when you say 'advisory to the Board', do you mean the corporate board or do you mean the Board, the corporate board and its servants?

10 THE WITNESS: And its divisions, the division...we use the word board rather in a wide fashion. When we might mean that the report is going to a specific division or department of the Board, the term is sort of a universal term that we...

DR. UFFEN: This might be tidied up for me, Mr. Laskin, if you were to pursue how and who appoints them.

15 MR. LASKIN: I'm going to.

DR. UFFEN: Thank you.

MR. LASKIN: Q. Well, let's start with that. Who does appoint these members of the advisory committee?

THE WITNESS: A. The board, the corporate board, has to approve the appointments.

20 Q. All right. What input, if any, do you have into those appointments?

A. Personally?

Q. Yes.

25 A. Not much. Not really any direct input. The appointments, of course, have to be mutually desirable and acceptable, but once there is a meeting of the minds in respect to a replacement, it is confirmed by the Board.

Q. Presumably the Board is getting some recommendation from someone with some medical expertise, as to who ought to be appointed?

30 A. In the past the recommendations have probably come first from the committee itself. There hasn't been very much



5 A. (cont'd.) turnover in this committee, and it has evolved that the replacements will try to be sought from the ministry, because of the necessity to travel for the advisory committee outside, the necessity to be frequently down at their headquarters where the pulmonary function laboratory is, and where an apprenticeship is easy, because those replacements have been there.

10 Q. It is not entirely accidental, then, I take it, that the first five members of the board that you named have or had at one time employment within the Ontario government?

15 A. It is not accidental at all. It is an evolution of the experience, and the perception of the need to employ Ministry of Labour employees, or Ministry of Health employees, that have had a fair amount of experience in chest disease. And this has been the case up to now.

MR. LASKIN: Dr. Uffen?

DR. UFFEN: Would Dr. Dowd or Dr. McCracken play any role in the recommendation for the membership?

20 THE WITNESS: Yes. We would all play a role. We would all be able to submit our opinion as to any replacement. No question. But the major decision would undoubtedly have to be made by Dr. McCracken as executive director, and by the vice-chairman of the Board.

I presume that that's the way it goes.

25 DR. UFFEN: Which one? The vice-chairman admin., or...the vice-chairman of administration?

THE WITNESS: Yes, yes. Mr. McDonald.

It would have to be...basically, as long as it would be acceptable to the advisory committee and to the medical branch, and...it would go through.

30 DR. UFFEN: This is a technicality, but then that recommendation will appear on the minutes of the Board at some



DR. UFFEN: (cont'd.) meeting, and there will be a recorded minute someplace?

THE WITNESS: I'm sorry. I don't know. I must confess I don't know what happens, precisely happens. I'm sure Dr. McCracken would know.

DR. UFFEN: Anyway, after the decision has been approved, the decision and recommendation approval, how does the person get notified that he has been appointed?

THE WITNESS: He is sent a letter by Dr. McCracken.

MR. LASKIN: Q. Is the letter that Dr. McCracken sent to the first five members that you named, would that be a different letter than the one that he sent to Dr. Gray and to Dr. Muir?

THE WITNESS: A. Yes. But Dr. McCracken came here in 1974 or 1975, so he hasn't sent letters to all the present members, and I cannot recall the exact nature of the letter or the correspondence that really went out on this.

Q. I suppose one question I should ask you, Dr. Gray and Dr. Muir's attendance at the advisory committee, is that at the request of the committee itself, or is the approval for their attendance coming from the board, the corporate board?

A. From the board.

Q. What's the tenure of appointment? Is it as long as the particular committee member wants to sit?

A. Yes, as long as...yes. Provided, of course, it works out, and I don't recall any member that, because of a personality problem or sickness problem, had to leave prematurely.

Q. So that there is no automatic renewal and there is no two-year term or three-year term or five-year term?

A. No.

Q. It's a lifetime term, for all practical purposes?



A. Dr. Ruddell, the original secretary of the silicosis referee board, served from 1928 to 1973...when he retired.

5 DR. DUPRE: Can I just ask you for a little history here? When did the silicosis referee board disappear?

10 THE WITNESS: It disappeared in 1968. Look, there are some years that have been suggested when the change of name took place, but I think Professor Barth is a little wrong when he says it was changed in 1970. Of course, he might have got that from me, but technically I think the order went through to change the name in October of 1968....the name itself.

15 DR. DUPRE: I see. Oh, basically the ACOCD simply absorbed the old silicosis referee board?

THE WITNESS: The name just changed.

15 DR. DUPRE: I see.

THE WITNESS: It's the same board.

DR. DUPRE: The silicosis referee board simply came to be called the ACOCD?

20 THE WITNESS: Yes. They felt that it really wasn't a board, it wasn't a referee...they weren't referees under the understanding of the Act...and they didn't any longer just deal with silicosis.

MR. LASKIN: Q. I take it that they receive some honorarium for their work, or is it more than an honorarium?

25 THE WITNESS: A. Yes. Each of them receive honorarium.

Q. Is it the same amount?

A. No, there are some differences. There are senior members and there's some junior members, and there are consultants. There's some differences in the emoluments. There's not a great deal, but there are some.

30 Q. How often do they meet?

A. I would...I don't have the exact figures in



5 A. (cont'd.) front of me. I would think they would meet anywhere from possibly twenty-five to thirty-five times a year.

Q. Where do they meet?

A. At 50 Grosvenor Avenue, the Ministry of Labour building.

10 Q. I take it you are not in attendance at any of these meetings?

A. In my fifteen years with the Board, I might have attended one or two...as maybe for an hour or so. I might drop down at the end of a meeting to discuss something, but I am never privy to their decisions in any way.

15 Q. Is any employee of the Board there, in a secretarial or administrative capacity?

A. No.

Q. To take notes or anything?

A. No. There never has been.

20 Q. Do you ever receive any minutes of meetings of the ACOCD? Are minutes kept, to your knowledge?

A. To my knowledge, no official minutes are kept.

Q. What kind of caseload do they have?

A. They will probably process possibly between four hundred and twenty to four hundred and fifty cases a year... claims a year.

25 Q. Do you have any feel or sense for how long it takes the committee to deal with the average case?

A. You mean the time lag, or the...

Q. No.

A. Oh, oh, of course. About three hours.

Q. Three hours a case? On average?

30 A. This would include pulmonary function studies,



A. (cont'd.) possibly a little longer if there were exercise studies included.

5 I would think that it might vary, but you must understand that I'm referring to examinations done in Toronto. The committee sends out several members several times a year, to different centers in Ontario, to examine claimants who have already had claims established.

10 First-time examinations are always done in Toronto, and the reassessment examination on a claimant that may have been given a partial award is done in any of the provincial chest clinics in the province - London, Sudbury, Timmins, Sioux, Kingston. They will go wherever there is an assemblage of claims that need to be reassessed, and it varies.

15 So I cannot give you precise information on the time spent in that examination.

MR. LASKIN: Dr. Uffen?

DR. UFFEN: Is there any minimum number of members required for an examination? Say they go to Kingston...

20 THE WITNESS: The examination? No. There's only one member only examines the man, and presents the claim to the committee.

MR. LASKIN: Q. Do you know whether the committee has a minimum quorum requirement by which it must come to an agreement?

25 THE WITNESS: A. I don't, really. No, I'm not aware of any hard and fast rule they have. I'm never there.

Q. Do you ever know, would the Board ever know whether certain committee members are not attending committee meetings, for example?

A. Not routinely.

30 Q. That information wouldn't get communicated to you?



A. Not necessarily.

Q. If there is a disagreement amongst members  
5 of the committee on a particular case, whether it be on diagnosis or percentage rating, would that disagreement get communicated back to you?

A. No, not usually. I can remember one or two occasions, but it's so exceptional that it's virtually negligible. I have assumed that not all doctors think alike, and presumably where a....a consensus is reached and the advice that we receive from the committee is a virtually unanimous consensus of the members.

Q. How do you get your advice from the committee? In what form does it come back to you?

A. It comes to us in a detailed report, if it's a first examination, a detailed report outlining the exposure, the details of exposure, the physical findings, the description of the x-ray, a description of the exercise tests that were done, pulmonary function studies, static pulmonary function studies, and electrocardiograms if they were taken down at the...if they were taken, and a diagnosis, and a recommendation regarding disability or impairment.

Q. I understood that whole catalogue of items that you just told me, except the very first one, which I thought you said was exposure.

A. The details of the exposure.

Q. I have the impression up until now, and please correct me, that that issue was dealt with by the claims adjudicator.

A. The claims adjudicator will send, or we will, or someone will, send the history of exposure, to the advisory committee, to aid the, of course, in determining causality. They have to have a detailed record, so that is always incorporated



A. (cont'd.) into the first report that we receive, as part of the medical report.

Q. Are they just then incorporating the evidence that...the finding that they already have on that issue, or are they, in some cases, supplementing it or changing it by virtue of their own inquiries on that question?

A. They will do both. They will generally inquire of the man of his exposure. They will simply not take it as it may have been sent down to us, and obviously they will rely on whatever we give them in terms of exposure, but they will set it down in their own way and may supplement it by their own questioning.

We rely on them to, if they need to have more exposure details, to ask the man or ask us to get it.

Q. But I take it they also, in some cases, find out that the original, what was originally thought to be an accurate exposure statement may not turn out to be?

A. Yes, that's possible. Yes.

DR. DUPRE: So basically, the only material that they could conceivably add to what is already in the file on exposure would be whatever information they receive in taking a very detailed patient history at the time of the examination, isn't that so?

THE WITNESS: Yes.

DR. DUPRE: Yes. Okay.

MR. LASKIN: Q. In terms of percentage rating, are you aware as to whether the committee has any criteria under which it operates, any schedule or guidelines under which it operates, to make that assessment?

THE WITNESS: A. They do. I would say prior to 1975, 1976, or a little later, before they really developed their pulmonary function laboratory, until now it is equal to any of



5           A. (cont'd.) the hospitals in the city, that  
estimation of impairment or disability was largely based on...  
was intuitive, was a judgement call that reflected the good  
many years of cumulative experience in the field, and now they  
are more prone to actually measure workability, and they do use  
activity equivalent graphs, as it were, to estimate disability,  
and to try to assign to the individual, and it depends on which  
way you look at this - either the functional disability lost  
through the injury, or the functional disability that is remaining.  
It's not easy to know how to express it.

10           Do you want to measure impairment that is lost,  
or do you want to measure the functional disability that remains  
to the person after that impairment is taken away?

15           And here again we're in a bit of a bog, that  
impairment is simply impairment of breathing, or  
impairment of ventilation. Disability is physical function, or  
inability to do a task or a job.

20           By exercise studies, one can fairly accurately  
get an idea of the maximum stress that that person can be  
expected to be exposed to, and generally equilibrate it to  
a level of work that is known, that have been set down and are  
fairly accurate.

25           We know roughly the amount of work and energy  
exposure that is necessary to do certain jobs - whether it's  
sitting at a chair, whether it's digging a ditch, whether it's  
mining or whether it's driving a truck - and by using exercise  
studies you can get a rough idea of the capabilities of the  
person.

30           However, the recommendation regarding the award  
I think will have to be taken in respect to what is lost. I think  
the stress is on what's lost, what has the man lost in terms of



A. (cont'd.) his functional...his functioning, his physical functioning.

5 I don't think that we've ever seriously worried about the terms disability and impairment, to try to distinguish between them, in our system.

10 A man who the committee recommends a thirty percent award, it means that that man has lost some thirty percent of his physical function...in their recommendation. It does not necessarily reflect the function that remains, because under our system it's not the function that remains that is important.

15 If you had a civil servant who by some freak accident lost his lung at work, his disability would be actually nil in respect to his particular job, sitting at a desk.

20 And if you took strictly a disability approach, he would get no award.

Under our system, that man would almost certainly be awarded a minimum of forty percent, fifty percent award for the rest of his life.

25 So it is not strictly a disability that is taken into consideration here, under our particular system.

I don't know if I make myself clear.

MR. LASKIN: This might be a good time to give Dr. Stewart a break.

DR. DUPRE: Do you want to take a break at this juncture? About fifteen minutes?

25 MR. LASKIN: Fine.

THE INQUIRY RECESSED

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THE INQUIRY RESUMED

30 MR. LASKIN: Q. Dr. Stewart, could you just clarify one matter for me in terms of the present composition



5 Q. (cont'd.) committee? Can you tell me, of the current members which of those members are also involved in the Ministry of Labour occupational chest disease service?

THE WITNESS: A. Only one - Dr. Roos.

Q. Only Dr. Roos?

A. Yes.

Q. I take it up until very recently, Dr. Vingilis was as well?

10 A. Yes. And Dr. Budlowski as well.

Q. And they both retired from the ministry?

A. Yes. They are...Dr. Budlowski, as I understand, is working part-time, however, with the ministry, on a part-time basis.

15 Q. In the chest disease service?

A. I'm not sure whether it's the chest disease service or the Ministry of Labour, but I think it's with the Ministry of Labour.

20 Q. I should have also asked you, are there any current plans afoot, of which you are aware, to augment or change the composition of the advisory committee?

A. We are presently thinking ahead, because it's a possibility that one or more may retire and we are actively thinking of replacements...at least one, possibly two.

25 Q. Again, are you looking back to the Ministry of Labour or the Ministry of Health?

A. Not necessarily. The easy replacement of members depends on the availability of the right person, and we have not...no decision has been made on this.

30 Q. Okay. Then just to complete the discussion we had just before the break on what you are getting from the committee and what you understand the committee is doing in terms of giving you a percentage rating, are you, yourself, or is anyone



5 Q. (cont'd.) else within the Board, its employees and so on, giving any instructions to the committee as to what you want from them?

10 A. There are no definite instructions given with each case. As I said before, all the committee has been asked to do, and is asked to do, is to give us a diagnosis and their assessment of the impairment or disability that resulted from it.

15 Q. Are there any instructions coming from you or other employees of the WCB as to the criteria for percentage disability, as you used the term...

A. No.

20 Q. ...or is it left to the committee to devise its own criteria?

A. We have not issued them any criteria. We rely on their expertise to give us an estimate of the disability.

25 Q. You indicated that up until about 1975, or so, it was generally a judgement based on their experience and so on, but that after 1975...

A. Also...excuse me...based also on pulmonary function studies, but not to the sophisticated extent that they have now.

Go ahead, sorry.

25 Q. The system that is now in place, is it any publishable form so that if I'm an outsider, could I look at some document which would tell me if certain pulmonary function tests are within certain, meet certain criteria, and your x-rays are such, that you will get X percentage rating?

30 A. In the last year or so, Dr. Roos has developed at least two documents that will...that I believe the committee now follows fairly well, and that you will get an idea of their...



A. (cont'd.) ...of how they achieve their rating.  
Yes, this exists.

5 Q. Do you have it? Do you have the documents?

A. I have it. I'm not sure I have it now. I can  
get it.

Q. Could you make those documents available to us?

A. Yes, I can...today.

10 Q. Now, you've told us that you get this report  
back from the ACOCD, and is it generally written by a particular  
person?

A. It is written by the physician who has examined  
the claimant, and is signed by that physician of the advisory  
committee.

15 Q. Does that tend to be...

A. For the committee.

Q. But is that function spread out generally  
amongst the committee members...

A. Yes.

20 Q. ...or does one person have a more particular  
responsibility?

A. No, they all are assigned cases to examine,  
and possibly Dr. Roos, who is the senior member now, will see  
more than the other members, but each member, except the  
consultants...

25 Q. Who don't?

A. Who don't. With the exception of Dr. Muir,  
who does, in Hamilton.

Q. Dr. Gray doesn't, but Dr. Muir does?

A. Yes. Right.

30 Q. I'll come to that in a moment, but just...if I  
understood your previous evidence, most of the cases on asbestosis  
that would be coming forward would already have an x-ray examination,



Q. (cont'd.) pulmonary function tests, done out of the chest disease service of the Ministry of Labour?

5 A. The pulmonary function tests would only be very minimal - the vital capacity and the FEV 1, that you would get from a portable spirometer.

Q. But those, I take it, those tests and the x-rays to the extent they are with a particular application for benefits, would be done by Dr. Roos, or under his direction?

10 A. Yes. At 50 Grosvenor.

Q. If you have that case coming forward, then is the patient then re-examined at 50 Grosvenor, by the advisory committee?

A. Yes, usually. Yes.

15 Q. So is it Dr. Roos, in the normal course, who would do that re-examination?

A. Not necessarily, although I do not know whether the committee has arranged it so that the original physician will see its patient. It's quite possible that they do. I don't know.

Q. You don't know?

20 A. No, I don't know.

DR. DUPRE: Presumably, how you find out is simply by looking at the form eight S of the attachments thereto, and if it turns out that the x-ray report is from the same physician as the physician who writes the ACOCD report, you have your answer.

25 MR. LASKIN: Q. Okay. Is it accurate that the report physically comes to you on Ministry of Labour stationery?

THE WITNESS: A. Yes.

Q. Any particular reason for that?

A. No one has ever thought about it. No one has ever considered it.

30 Q. Now, in terms of the percentage ratings that you get, how many gradations do you tend to see, and are



Q. (cont'd.) we looking at ten percent, twenty percent, thirty percent, or how finely tuned are the ratings, if you will?

A. You just mentioned it - ten...

Q. Every ten?

A. Yes. That is possible.

Q. But I mean, would you see something like fifteen or seventeen?

A. No. No.

Q. It's basically ten percent, twenty percent, thirty percent, all the way up in gradations of ten?

A. Yes, as far as I remember.

Q. Okay.

A. Yes, I think it's gradations of ten.

Q. Fair enough.

A. I suppose a thirty-five could sneak through, but I don't...I can't remember it.

Q. All right. What do you do with a report once you receive it?

A. I look at that report and I go through it very carefully, and if I feel that any clarification is needed, I will ask for clarification...if the x-ray description or the diagnosis and the conclusions are cloudy, I would like to know more. I rarely do this, but occasionally I have asked for clarification and sent the report back. The great majority, I do not.

Q. With the great majority of reports, what do you do with them?

A. I send them to the disease and dependents section, to the co-ordinator.

Q. The claims adjudicator? The co-ordinator?

A. Yes, they go to Mr. Ranta. I don't know quite



A. (cont'd.) directly where they...

5 Q. All right. Do you give any opinion along  
with that of the advisory committee?

A. No, I do not. I merely ...

Q. You route it onwards?

A. I merely route it onwards. Unless there is  
something unusual about.

10 Q. If there is something unusual, do I take it  
that what you would do in the normal course would be to send  
it back to the advisory committee? You would not change the  
advisory committee's decision?

15 A. No, no. I would merely...the advisory  
committee's report may request certain actions on the part of  
the Board. In that case I would ask, eventually, for the file  
and deal with it. They may wish to have additional information  
from a hospital, or they may have found that a biopsy was done,  
and so I will ask for that at their request.

20 Q. They may want more information?

A. Yes.

25 Q. In which case you send the file back,  
ultimately, to the advisory committee?

A. I would get the information for them and send  
it to them. Otherwise, I send the completed recommendation to  
the claims department.

30 Q. The recommendation that goes to the claims  
department, then, would always be that of the advisory committee?  
You would never change that recommendation?

A. I cannot remember an occasion on which I have  
ever changed, unilaterally, a recommendation. If I ever would  
consider it, I would certainly...first of all, I would check with  
the advisory committee.

I suppose in my fifteen years, I might have on one



A. (cont'd.) or two occasions done this, but in  
the mist of time, I can't remember it really. It's so infrequent  
it's negligible, or zero, really.

5

Q. Now, the claims co-ordinator then receives  
the recommendation?

A. Yes.

Q. And I take it...

DR. DUPRE: You mean the claims adjudicator?

10

THE WITNESS: Claims adjudicator.

MR. LASKIN: Claims adjudicator, I'm sorry. Did  
I say...claims adjudicator.

15

MR. LASKIN: Q. And I take it you've got two  
classes of recommendations that would be going forward. One  
class of recommendation would be denial of entitlement, and a  
second class of recommendation would be entitlement and a  
percentage rating.

THE WITNESS: A. Yes.

20

Q. Okay. On the first class, denial of entitlement,  
the claims adjudicator then does what?

A. Well, they will send a letter to the...they  
will send the claim to the review branch.

Q. Automatically?

A. Automatically, I believe. Now, this is my  
understanding of it. And if this is confirmed, then a letter is  
sent to the individual concerned.

25

Q. Have you ever had an instance where the claims  
review branch would say we have some problem with this opinion, we  
would like it reconsidered?

30

A. It's possible of course, but I do not remember  
a specific instance in respect to asbestosis claims, that this  
has occurred.

I am not saying it has not.



Q. But you can't recall any?

A. I can't recall.

Q. So that...

DR. DUPRE: Just to make sure I have the picture straight. From time to time the claims review branch has returned a claim to you when it has been your decision not to forward it to the ACOCD. But with respect to claims that have been forwarded to the ACOCD, and the adjudicator is told to deny, the claims review branch has never asked for a reconsideration, to your recollection, in asbestosis cases?

THE WITNESS: I can't remember.

DR. DUPRE: The first part of my recollection, which was from your earlier testimony, is correct, right?

THE WITNESS: Right.

MR. LASKIN: Q. So that at least to your recollection, what the claims review branch has done in all those cases is adopt the recommendation of the advisory committee and so advised the claimant?

THE WITNESS: A. Yes.

Now, dealing with the other class of case, the entitlement case with a percentage rating attached to it, what does a claims adjudicator do with that case?

A. Well, the mechanics of what he does, I'm afraid, precisely...I wish I could describe them to you. I'm not precisely familiar with the mechanics of the work of the claims department after they receive such a claim. Now, they will obviously compute the award based on the salary, and they will process that award To the exact way they do it, I don't know.

Q. Fair enough.

Is there ever a case where the claims adjudicator will say, I'm a little concerned about the percentage that the advisory committee has attached to this particular case, and I



Q. (cont'd.) would like that matter reconsidered?

A. Once again, I don't recall it in an asbestos claim. It has happened occasionally in other claims, but very occasionally, again, in which there has been a question mark based on the medical report. It happens occasionally, but once again, it could have happened in asbestos, but I just really don't know.

Q. Do you have any recollection of any instance in which the claims adjudicator on his own, or on her own, has changed a recommendation of the advisory committee, on percentage?

A. I would say that based on my knowledge of the approach of the claims adjudicator, that this would not happen, and that if the claims adjudicator felt a change was necessary, he or she would go to their superior, and their superior would then contact me on this.

So I still can't remember such occasion.

Q. Such an occasion? Who would their superior be?

A. Mr. Ranta, Ray Ranta. He would be their superior in the disease and dependents section.

Q. Do claims which are allowed at a particular percentage, do they, to your knowledge, in the asbestos field, or have they got to the claims review branch?

A. The claims that are...

Q. Allowed?

A. ...allowed? I'm not aware that allowed claims go to the review branch automatically.

Q. Let's assume...can we take the process one stage further into the appeal stage, and again let's first of all take an appeal against nonentitlement, which has been determined by the claims review branch and which we have heard, from Mr. McDonald, will go to an appeals adjudicator in most cases.

Now, do you or does the advisory committee get reinvolved in such a case?



A. Yes, we may.

Q. Okay. How does that happen?

5 A. The claim will be sent back to me with the details of the appeal...the evidence presented at the appeal... and I will generally be asked if in my opinion this evidence is of such a nature that our recommendation can be changed.

In essence, that's it. Now...

10 Q. Who is asking you that?

A. The claims department. Well, the appeals adjudicator, yes.

DR. UFFEN: When you say 'our recommendation', you mean yours or the ACOCD?

15 THE WITNESS: Mine.

DR. UFFEN: Or one or the other?

THE WITNESS: Well, let's say my recommendation or the ACOCD. Yes, both, because I may, in effect, send that appeal and ask the committee their opinion of the evidence that has been presented. But I may do it myself. I may make the decision myself.

20 MR. LASKIN: Q. I just want to understand...

THE WITNESS: A. Make my recommendation myself.

Q. Yes. This happens in every appeal in which the subject matter in which you are involved, let's say asbestosis claims, every appeal, then, to the appeals adjudicator, the appeals adjudicator would ask you for your opinion on the evidence?

25 A. Yes.

Q. After the evidence had been presented?

A. Yes.

Q. What you are telling me is that you may make.. you may give the appeals adjudicator an opinion yourself as to 30 your view of the evidence?



A. Yes.

Q. Or you may seek further guidance from the  
5 advisory committee?

A. Yes. It's quite likely that I will refer it back to the committee.

Q. In either event, you then deliver a written opinion back to the appeals adjudicator?

A. Yes.

10 Q. Have there been occasions in asbestosis claims where your opinion, or more particularly the advisory committee's opinion, has been changed as a result of the evidence heard on an appeal?

15 A. I don't recall. It's possible, of course, but it's possible too that the advisory committee may take cognizance of the evidence presented, and change its view. That is possible. I think it has happened, but I think it's probably rare. There must be some substantive evidence presented that will overthrow the conclusions of the committee that were based on very, very detailed analysis and examination and pulmonary function tests. The mere fact of an appeal - there must be something accompanying the appeal, something that would change, organically change, the complexion of the case. And that's why there are probably very few occasions which I can remember, if any, that an opinion has been...the recommendation has been changed by an appeals adjudicator.

20 25 MR. LASKIN: Dr. Uffen?

DR. DUPRE: In all claims? This is in asbestosis claims only?

30 THE WITNESS: I'm talking of asbestosis, but this refers to any chest claim. This may refer to any chest claim, this procedure, but as far as changing the recommendation of the advisory committee, I don't recall many occasions, if any, in



THE WITNESS: (cont'd.) which there has been a change,  
in which an appeals adjudicator has recommended a change of the  
recommendation by the advisory committee.

DR. UFFEN: Would there ever have been a second  
medical examination of the patient by a different member of the  
advisory committee? Was the first direct medical examination by  
one member?

THE WITNESS: Yes.

DR. UFFEN: And at the appeal stage, would they ever  
have had him re-examined, or an independent examination and opinion?

THE WITNESS: No, not very often. I cannot recall  
an occasion when, because of an appeal...well, there could have  
been the odd occasion that because of an appeal the man is  
re-examined by the committee, but it doesn't happen very often.  
I just can't recall.

DR. DUPRE: Maybe, Dr. Stewart, I ought to just  
do something very elementary, that I should have done before. I  
want to make sure that I understand the range of claims in which  
the ACOCD will be involved.

They will always be involved in asbestosis claims?

THE WITNESS: Yes.

DR. DUPRE: They won't be involved in claims  
involving mesothelioma?

THE WITNESS: No.

DR. DUPRE: Okay. Will they be involved in lung  
cancer claims?

THE WITNESS: No.

DR. DUPRE: No. They will be, then, involved in,  
besides asbestosis claims, claims for survivor benefits when an  
asbestotic has died?

THE WITNESS: Maybe.



DR. DUPRE: Maybe?

THE WITNESS: Not always. Unless we send, unless  
5 we request their opinion as to...

DR. DUPRE: Okay.

THE WITNESS: ...the merits of a claim, a death  
claim.

DR. DUPRE: So basically, the ACOCD will, with  
10 respect to the whole range of asbestos-related diseases, (a)  
always be involved in asbestosis claims, and (b) occasionally  
be involved, on request, with respect to survivor benefit claims  
that are forthcoming from asbestositics?

THE WITNESS: Yes, that is true. That is accurate.

DR. MUSTARD: Can I ask a question about this?

15 MR. LASKIN: Yes.

DR. MUSTARD: How do you resolve the problem which  
may or may not have occurred, but could occur, in which the diagnosis  
of a cancer in the gastrointestinal tract creates a problem as to  
whether it's a cancer of a specific organ such as the pancreas, or  
a mesothelioma, if you have that kind of difference of opinion?  
20 How do you resolve that, do you use the advisory committee?

THE WITNESS: We will...no, we do not. That  
will generally require a tissue diagnosis, so we will eventually  
get tissue and send it to Dr. Ritchie.

I cannot recall any claim involving a mesothelioma,  
25 peritoneal mesothelioma or pancreatic cancer, in which tissue was  
not obtained. I do not think we have accepted any claims of  
that nature without tissue. We would not send this to the committee.

DR. DUPRE: Counsel, I wonder if I might suggest  
this, that we continue to pursue all of the questions we have been  
asking about the ACOCD, in terms of what it's doing, but then be  
able to come back and go right through what happens to the other  
30 kinds of claims...cancer claims, mesothelioma claims.



MR. LASKIN: That's what I was...I was proposing  
to do that.

5

DR. DUPRE: All right.

MR. LASKIN: Q. Just to follow up on the Chairman's  
questions here, there is a statement at page two point two eight  
of Barth.

THE WITNESS: A. Yes.

10

Q. If you look in the first full paragraph, he  
says:

15

"Virtually all the cases involving asbestos,  
that go to the ACOCD are for asbestosis claims.  
For the sake of accuracy it should be noted that  
on some occasions claims for asbestos-related  
diseases not involving asbestosis are referred to  
the ACOCD."

Can you comment?

20

A. Yes, I can comment on that. First of all, I  
occasionally will ask the committee to assess a claimant who has  
an injury or a pulmonary disease not associated with mineral  
dust, and who comes within my sphere of responsibility in respect  
to the estimation of awards for permanent disability awards.

25

Because of the complexity of these cases - some  
involve trauma to the thorax, mostly trauma to the thorax,  
occasionally other claims - I will ask the advisory committee to  
submit an opinion.

30

It is submitted to them as a special claim, a  
special request, and they deal with it in that way.

So it's not precisely true to say that they just  
deal with the pneumoconioses. They will deal with almost any  
claim involving pulmonary injury, which I will send them...as long  
as they can work it into their schedule.

So in that respect they will see the odd claim



A. (cont'd.) that doesn't involve pneumoconioses.

Q. All right. Just coming back to the routing  
5 of an asbestosis claim through the appeal structure, we got to the stage of the appeal adjudicator, and I take it generally your evidence was that if there was a case where an appeal adjudicator changed an original recommendation of the advisory committee as a result of hearing evidence, it would be a rare case and you can't recall one in the asbestosis field?

10 A. In my opinion it would be rare. It's certainly possible. I wish I could have these numbers for you, but I really...

Q. I take it your answer includes both appeals on entitlement and appeals on percentage ratings?

15 A. Both, yes.

MR. LASKIN: Dr. Uffen, did you...

DR. UFFEN: Does the...yes...does the appeals adjudicator or the manager of appeals adjudicators have the right to call in outside medical advice?

20 THE WITNESS: To my knowledge, yes. He can hold hearings and the individual who is appealing, the appellant, may call his own witnesses.

DR. UFFEN: Does this happen very often?

25 THE WITNESS: I'm trying to recall. I wish I could really. I'm sorry, again. I can't give you an idea of the frequency of that, or of the kind of evidence that he may mobilize on his behalf.

DR. UFFEN: If he did, would he go to the members of the advisory committee, or the consultants, or would he go to whatever expert seemed appropriate and available?

30 THE WITNESS: He may or may not recommend that someone else see the patient. That's the adjudicator's right, to recommend that he be seen by someone else.



THE WITNESS: (cont'd.) He will not...he may, at the same time, ask the advisory committee to reconsider the claim, based on this evidence.

I think I said before that this frequently happens, that if an appeal goes through at this level, almost certainly the advisory committee will hear of it and will be asked to comment on whatever evidence has been presented at the hearing.

DR. UFFEN: That clears up the thing that I was wondering. There is a route whereby a second medical examination can be obtained, and it's through the appeals adjudicator?

THE WITNESS: Yes. I cannot give you the frequency with which this is done, though. But it's there.

MR. LASKIN: Q. Can you confirm Mr. McDonald's evidence given to us previously that neither you nor any member of the advisory committee have ever given viva voce, oral testimony, on an appeal before the appeals adjudicator?

THE WITNESS: A. I have never given any. Never.

Q. In any appeal, whether at the appeal board level...

A. At any appeal level. I have never been present.

Q. Have you ever been asked?

A. Never. I cannot recall being asked to be present at any appeal.

Q. Not by a claimant? An appellant?

A. I cannot remember that either. If the request came through, it might not have reached me, but I can't...

Q. Is there any practice of which you know within the Board which would preclude you from giving evidence as a witness, if you were called?

A. It's my understanding that it's just not done. I have never questioned the custom. I never thought about it, really.



Q. Okay, can we move one step higher, to an appeal before the appeal board?

5 A. Yes.

Q. Are there occasions when either you or the advisory committee become involved once again in a case at that level?

A. Yes, definitely.

Q. Does that happen as a matter of routine?

10 A. I would suggest that it would be, that if I had been involved in a case that has gone to the appeal board level, the appeal board will request my comments on the testimony or the evidence that has been presented at the appeal.

Q. After the evidence has been heard?

15 A. After it has been heard, set down either in transcript form or in summary form.

Q. That's what I was going to ask you. How do you get the evidence that you are being asked to comment upon?

20 A. It's sent to me in transcript form, with the claim. The claim is sent back to me.

Q. Would you get the actual transcript of the evidence?

A. Yes.

Q. Or do you get a summary from the appeals administrator?

25 A. In some cases, it's a transcript. In some cases it's a detailed summary. There is not always a transcript.

Q. And do you again seek the advice of the advisory committee in certain of those instances, or do you give the opinion yourself?

30 A. I will give an opinion. I will usually give an opinion, but I also may request an opinion of the committee.

Q. So there may be two opinions going out?



A. Yes.

Q. Do they ever diverge?

5 A. There are not that many of these cases, and I can't recall a divergence of opinion.

Q. Do you recall any instance at the appeal board level where either your opinion or that of the advisory committee has recommended a change from the original opinion upon which presumably an appeal has been based?

10 A. You mean based on the evidence at the appeal?

Q. Yes. Based on the evidence at the appeal board level.

A. Really, I'm sorry, it's possible, but I can't recall it. But it's possible.

15 Q. It would be a rare instance again, I take it?

A. I think so. Can I maybe...could you just phrase that again? Let me just make sure I understand.

20 Q. What I'm interested in knowing is, whether you can recall any case in the asbestosis claims appeals where the evidence read before the appeal board hearing has caused the advisory committee to change its opinion, or indeed has caused you to change your opinion?

A. I can't.

25 Q. What about...does the situation ever arise that by virtue of...and I don't know what time lapse we are talking about..but by virtue of the time lapse between the time the case first went to the advisory committee and it gets ultimately considered at the appeal board level, a particular claimant's asbestosis may have progressed. He may be now worse off just because it's a progressive disease, and if so, does that get considered on the appeal?

30 A. I don't think that's likely, but if it was pointed out and possible, then he would be reassessed. But apart



A. (cont'd.) from that addition, I don't think that the delays are that great that we would consider it a critical thing in the claim.

5 But if it was pointed out to us and if it was in fact obvious, we would not hesitate to send it back to the committee.

Q. Who would point it out to you? Presumably an outsider...

10 A. Well, if in fact I dealt with the claim two years before and now I see it again, and that person has not been reassessed by the committee in that time, then it's quite likely that if it was asbestosis and...he could be sent back for his reassessment - a routine reassessment which applies to all people who have this disease and who are followed by the committee.

15 Q. To ask Dr. Uffen's question, at the appeal board level is there any re-examination of the appellant, claimant?

20 A. There could be, of course. There could be, if the evidence that was presented led us to conclude that the original examination was out of date, or that brought to our attention some fact that would indicate a...yes, we would definitely do it. I cannot tell you if we have, or how often, but we would.

25 DR. UFFEN: I'm just interested - who would decide whether or not it would be done?

THE WITNESS: At the appeal board...at the appeals adjudicator level, the appeals adjudicator might request it. In that case the request would be followed to the letter.

30 If it was a question posed to me, I might or might not recommend it. But...

DR. UFFEN: But at the appeal board level?



THE WITNESS: Oh, the appeal board level? Oh, well, if they requested a re-examination, it would certainly be done by the committee.

5 Is that what you mean, Dr. Uffen?

DR. UFFEN: Yes, that would be it. They would decide and they would do the...issue the invitation and so on?

THE WITNESS: Oh, yes. And they have. Oh, yes.

10 MR. LASKIN: Q. Okay, can we turn to...there are two other classes of cases that I wanted to deal with you on - the cancer claims and then the death claims, and can we turn to cancer claims, asbestos-related malignancy claims, and again initially you get a file from the appeals adjudicator...I'm sorry, from the claims adjudicator?

15 THE WITNESS: A. Yes.

Q. And there are the usual forms in the file?

A. Yes.

Q. What other information, if any?

20 A. Exposure information is usually on the file. Frequently tissue, biopsy analysis, hospitalization records are on the file, x-ray reports are on the file.

Q. These are living claimants?

A. Yes.

Q. You still get that?

A. Yes.

25 DR. DUPRE: Could I ask the following, counsel?

In terms of in the cancer cases, the doctor's report, would that be the form eight S, the one that's in Barth's study, or would it be a different one, because the form that's in the Barth study has form eight S down at the bottom, but then it says doctor's report, occupational chest...

30 THE WITNESS: It might be on that form. It might be in the form of a letter or a simple report.



DR. DUPRE: Oh, I see. So in other words,  
there isn't a form for the cancer diseases?

5 THE WITNESS: No, no.

DR. DUPRE: Okay. So it's either in the form of  
a letter or a form eight S. Thank you.

MR. LASKIN: Q. What, then, do you do with the  
file that you get?

10 THE WITNESS: A. If there is enough information  
on that file regarding diagnosis and regarding exposure, we will  
offer the claims department our recommendation regarding causality,  
whether we feel that the disease is a compensable one, and we  
will so recommend on a memo, a written memo on that file.

15 Q. You may do that, I take it, on the basis  
of the evidence you have in the file, without necessarily seeing  
the patient, the patient/claimant?

20 A. We rarely see a patient. We are asked to  
comment on causality, not on clinical condition of the patient.

Q. But I take it part of the determination on  
causality may include requiring a proper work history and so on?

25 A. It's usually attached to the file.

Q. And if it isn't?

A. We will always...

Q. It's up to the investigator?

30 A. We will always require adequate medical  
documentation. We will never simply just accept just a tissue  
report. We will insist on getting the background to it, and  
so that we are convinced that the cancer is the primary one and  
not a secondary, and it's the type that is covered under the  
guidelines.

Q. Are you responsible for making the diagnosis  
of the cancer?

30 A. I am responsible for the decision regarding



5 A. (cont'd.) causality. I have to be satisfied that the diagnosis has been established...correctly established.. by the physicians, dealing with the man's own physicians, and as long as I'm satisfied that in truth what we have is the diagnosis, we will act on that.

Q. You make that determination alone, or are there occasions when you would seek assistance from others on that determination?

10 A. Frequently we ask Professor Ritchie to review the tissue. In a substantial percentage of cancer claims, we will ask him to review the slides that have been prepared by the pathologist, and also uncut tissue, block tissue, so he can prepare his own slides. This is not...we don't do this in every case of cancer. If we are uncertain as to the diagnosis...in fact if we are not certain that it's accurate...we will ask for this.

15 Q. In addition to determining causality, are you required to assess percentage impairment? Does that issue arise?

20 A. Yes, it does. It does.

Q. You make that assessment as well?

25 A. We will make that assessment after a suitable period of time, after the treatment if treatment is being carried out, or after a suitable pre-operative time, after a part of the lung has been taken out, we will then bring to the claimant to the Board and assess him for disability resulting from that - either from surgery or from radiation.

Q. If you have made an assessment of...if you have made a determination of causality?

30 A. This is assuming, of course, that the claim is accepted.

Q. Yes.



A. Okay.

5 Q. You have made an assessment of causality and the claim is accepted. I take it there are some benefits, then, that will flow to the claimant in the period between which you have made that assessment and the time you put a percentage rating on it?

10 A. We would generally recommend that during the treatment period that he be fully compensated, until treatment is complete, until his condition is stabilized, and only then will we bring him in to measure residual impairment which will...

15 Q. In the intervening period is he getting...

A. Full compensation.

Q. Temporary...

15 A. Temporary total compensation. Yes.

Q. So you then forward your determination of causality, and ultimately residual impairment, onto the claims adjudicator?

A. Yes.

20 Q. Again, can I ask you whether in the asbestos cancer field whether you are aware of any instances in which the claims adjudicator has disagreed with you?

I suppose I should take it back a step, because if your view is there is no causality, that case, I take it, automatically goes to the claims review branch?

25 A. Yes.

Q. Can you remember a case where either the claims adjudicator or the claims review branch has disagreed with your opinion?

30 A. I can't, so I think it's rare that it has ever happened. I wish my memory was sharper, but I feel that it is a rare bird.



Q. That's fair enough.

5 Then, just taking the matter through the appeal structure, again if a case, let's assume a case of denial, a finding of no causality, is appealed, do you become involved again in the case?

A. Quite likely, yes.

Q. In the same manner?

A. Yes.

10 Q. That is after the evidence has gone in?

A. Yes.

Q. Is that similarly true at the appeal board stage?

A. Yes.

15 Q. Then can I ask you, can you recall any instances when you have changed your opinion, first of all, as a result of the evidence heard before the appeal adjudicator or the appeal board?

20 A. On a cancer claim? Oh, gee, I suppose it's possible.

Q. One doesn't come to mind?

A. One doesn't come to mind.

Are you talking at the appeals adjudicator level or the appeal board level?

Q. Either.

25 A. I can't recall.

Q. Again, I take it because of that it would be a very rare instance if it did occur?

A. Right. Not very many...these are not many cases you are talking about.

Q. No, I appreciate that.

30 A. Okay.

Q. But I take it, nonetheless, within that not



Q. (cont'd.) very large class of cases, it would be very rare?

5 A. Yes, I think it's true. It would be rare.

Q. Do you recall any instance in which either an appeals adjudicator or the appeal board has differed with your opinion?

10 A. Well, I know that the appeal board has differed and has arrived at different conclusions, that they have accepted a claim that possibly I might have recommended that there was no causality, on one or two occasions I think this has certainly happened at the board level.

15 In fact, it may have happened more than I realize, but I don't necessarily know of some of the results of these appeals. In fact, I know that I have not known some of the results of the appeals, and some of them have been...the board has decided to go against a recommendation of mine...in not necessarily the asbestos, but in other claims. They have decided on other...

20 Q. In terms of mesothelioma claims, we've heard a lot of evidence at various times, both last summer and this, about the difficulties in diagnosing mesothelioma sometimes.

Have you ever utilized the mesothelioma panel, for example?

25 A. Since we accept virtually all claims of mesothelioma, where there is documented exposure of any sort, and since almost in all our claims a tissue diagnosis has been clear, the problem hasn't arisen - at least in our view.

30 We have had at least one appeal involving a pancreatic, possible pancreatic cancer, which was referred to a pathologist, an independent pathologist. It had already gone to Dr. Ritchie, but it was referred by the board to another pathologist, and based on this report the board decided to



A. (cont'd.) accept the claim as a mesothelioma claim and not one of pancreatic cancer.

5 This is the only, I think the only occasion that I can remember where there was a problem dealing with mesothelioma claims.

Q. In terms of diagnosing whether it was mesothelioma or some other kind of malignancy?

10 A. Yes. Don't forget, Dr. Ritchie sees most of them. We send most of them to him. They have proven a problem in the past to some pathologists, and hence some pathologists have sent their material to Dr. Ritchie.

So eventually we are satisfied of the diagnosis.

15 Q. Have there been any mesothelioma claims that you have rejected?

A. Yes, we have. We have rejected five or six in the history of the Board.

Q. What are the grounds for rejection?

20 A. Only one - no documented exposure whatsoever. We have gone into this in detail in most of those claims.

Q. You have been satisfied that in fact it was a mesothelioma?

A. Yes, we have.

Q. And what you haven't been able to do is demonstrate any exposure to asbestos?

25 A. That is right.

Q. Just so that I'm clear, is it as all-embracing as that - no exposure to asbestos, or no work exposure to asbestos?

A. No occupational exposure, in the sense of the word, that generally-accepted sense of the word.

30 Q. Have you been able to determine whether, in these five or six cases, there might have been nonoccupational exposure?



5 A. I think in one or two we had some suspicions that there might have been, but I can't really give you much more than that on these claims.

10 We look to see, we look very hard to see, for occupational exposure in any mesothelioma claim. We will ask the occupational health branch to visit the workplace, to give us an opinion, and we have. And if we cannot document occupational exposure from any direction, we are not able to recommend causality, and the claims department is not able to deal with it since there 15 is no occupational exposure.

Q. To asbestos?

A. To asbestos, yes.

20 Q. Are you looking at any other substance as possibly causing mesothelioma?

A. Oh, yes. I can recall one occasion in which talc was involved, which was tremolite - there was tremolite, and I believe that that was a deciding factor, that we accepted the mesothelioma based on tremolite exposure.

25 But I cannot recall any other substance which would be involved - apart from asbestos.

Q. Was there any working hypothesis that you or your colleagues, your professional colleagues, had as to the causes of these five or six mesotheliomas?

A. It is our understanding that a certain number of mesotheliomas have no documented exposure.

30 Now, you can argue that it's unknown and that exposure had taken place. I do not think that there is a unanimity of opinion amongst experts on that, and I spent three days in Montreal attending that international meeting, and I cannot...I had to come from that meeting concluding that there was no answer to your question - that you would have to expect that



A. (cont'd.) there would be mesotheliomata that would occur spontaneously, without necessarily having asbestos exposure.

DR. UFFEN: Those that were due to asbestos exposure of a nonoccupational type and undocumented?

THE WITNESS: Yes. But you could also argue that like any cancer it could appear spontaneously, without necessarily having asbestos involved.

DR. UFFEN: I'm thinking about the possibility of someone...not in their work at all...but I'll give you an example, has a habit of sawing up asbestos boards at his summer cottage for everybody else in sight...it was his avocation, but he still exposed himself, and then when you do a post mortem on him and you find asbestos, it should be a surprise, but it would not be occupationally related.

THE WITNESS: I think it's true some of these can be explained that way, but...

DR. DUPRE: With respect to these five mesothelioma cases where they were never able to find any exposure...

THE WITNESS: There were six, I think, Mr. Commissioner, maybe six.

DR. DUPRE: Five, six, whatever. Did you have autopsy material on any of those cases?

THE WITNESS: I think, as I said before, we have tissue diagnosis on every patient. Now, I cannot be certain as to how far we went into the reject claim. If there was no exposure, I cannot be certain that we would necessarily go into it in as great a detail as we would where there was documented exposure, so I better not answer your question with certainty.

On the claims that we have accepted, we have had



THE WITNESS: (cont'd.) tissue diagnosis on every one.

5 On the ones that we have rejected, we might not necessarily have asked the pathologist concerned to send it to Dr. Ritchie, his slides, because if it wasn't...if there were no occupational exposure, technically the Board cannot accept the claim. Technically, they don't need our recommendations. They don't need our recommendations, in fact.

10 But I'm afraid I must say I don't know the details of the six claims, exactly. I would have to go into them.

MR. LASKIN: Q. Okay, can we just turn very briefly to the last class of claims, or perhaps not so briefly, and that is the death claims?

15 THE WITNESS: A. Yes.

Q. The kind of situation that we are interested in learning about from you is the case where there is a worker receiving a partial permanent disability for asbestosis, who then passes away. The cause of death is stated to be other than asbestosis, a claim is put forward by one of his survivors or 20 her survivors, for benefits.

First of all, just backing up a moment, can you help us with a point that we discussed yesterday, which was - is there any routine within the Board to notify the survivor of the possibility of a benefit? Of which you are aware?

25 A. Under what conditions, now, are you...?

Q. Just that example. A worker on a...

A. With a partial?

Q. Partial.

A. And who...?

Q. Dies.

A. Who dies, and we are informed of the death?

30 Q. Yes.



5           A. The claims department will always be informed of the death, and they will see the claim before we do, at the medical level.

Q. Let's step back a moment. How is the claims department always informed of the death?

A. Well, I must confess I really don't know the mechanics of that. Presumably someone will inform them, and they will notify me.

10           Q. I guess we may be talking at cross purposes, because the stage I'm interested in is who, if anyone, notifies the survivor that a claim could be put forward? I'm one step behind you.

A. That will be the claims department. We will not notify it from the medical department.

15           Q. And I take it you can't help me as to what routine your claims department has in that regard?

A. No, I'm not really familiar with it.

Q. Do all claims for survivor benefits, in that kind of situation I gave to you, come to you? Or to Dr. Dyer?

20           A. Yes.

Q. You have attended at least parts of the sessions we have already had, so that I think you will be aware of the problem we are concerned with, and that is how you assess whether or not asbestosis has played a sufficient role in the death...and I use that term advisedly...so as to entitle the 25 survivor to benefits?

A. Right.

Q. Can you, before we become more specific, tell us generally what your own approach is to that problem?

30           A. If an individual has a partial pension for asbestosis, dies of noncardial pulmonary conditions, or including and who does not die from an asbestos-related cancer, we will



A. (cont'd.) look very hard at that claim before we recommend that a death claim be accepted.

5 Now, let me give you an example. If a person who has a thirty, forty, fifty percent pension for asbestosis dies of a stroke, dies of...we would probably not recommend that that claim be accepted.

10 If he dies of a coronary, an acute coronary episode involving a myocardial infarction, involving acute coronary thrombosis, we might not recommend that there be a causal connection assumed.

15 Each claim, of course, has to depend on its peculiar circumstances, and it is correct in saying that we do not automatically recognize a connection between pulmonary fibrosis and coronary artery disease.

20 The mere presence of pulmonary fibrosis or the development of it, we have never been...we have not seen evidence, nor could we have deduced, that the development of coronary artery disease is connected with either asbestosis, uncomplicated asbestosis, or silicosis.

25 I feel that it is, coronary artery disease is hereditary, it is a lifestyle problem, a lifestyle-type of disease. This is not to say that we will not consider it, but I can give you a broad opinion that unless there were some unusual circumstances, we would not.

Perhaps you should...

25 Q. Well, I may rely upon my medical expert commissioner, but let me just pursue it a moment.

One of the things we have heard is that if you have right-sided heart failure, that is one connection that you will recognize. Is that accurate?

30 A. Absolutely, yes. Yes.

Q. Are there any other kinds of connection that



Q. (cont'd.) you will recognize in the same way?

A. You know, it's very difficult to answer that question. It would be much easier to answer if you gave me a proposition or you put something in front of me and I could answer it, and gave me the details and the circumstances.

Each case is so different that there are a million different possibilities and...

DR. DUPRE: But since a right-side heart failure is not a complicated matter, you will accept that?

THE WITNESS: Without any doubt.

DR. DUPRE: Okay.

Pneumonia is not in the same category, is it?

THE WITNESS: Once again, pneumonia - we would look closely at pneumonia as a primary diagnosis. If a person is receiving fifty percent for asbestosis, for example, and he dies of a primary pneumonia, I cannot see that we would not accept that.

But, we might not accept a secondary or terminal pneumonia that might follow another condition.

If the person had kidney disease or some other disease and he was debilitated and died bedridden, of pneumonia, we might not conclude that the asbestosis was responsible for the pneumonia, that it was connected, as a terminal event connected with the other fatal condition.

In that respect we would have to look at it closely.

I might add that on occasion...well, not rarely, not infrequently in the past, we have received death reports. We have received death certificates signed by physicians, listing pneumonia as the cause of death. And on more than one occasion, however, the death certificate did not contain the reason and it was a post-operative coma, or some accident, that led to



THE WITNESS: (cont'd.) the bedridden existence, and the secondary pneumonia, the terminal pneumonia.

5 So we will have to look closely at the nature of that pneumonia, whether it's a primary or a secondary to something else.

10 DR. MUSTARD: How can you handle this argument: That there is, I think we would agree, good documentation that where you have chronic chest disease your susceptibility to viral and bacterial infections is increased. That seems to be an accepted phenomenon in human health.

15 Now, I go and have an operation for something else, but I still have my chronic chest disease and I come down with a terminal pneumonia. How can you exclude the argument that if I had had healthy lungs and had the operation, even if it's...that I wouldn't have gotten into this terminal state with the pneumonia - that in effect the pneumonia obviously has come as a consequence of my having the operation, but because I've got the chronic chest disease I was much more vulnerable?

20 THE WITNESS: We would not exclude it. I'm sure in the past we have accepted that premise. I can't say that it's with asbestosis, but it's with other chest disease claims, and that we have not excluded that. We accept your point, and I think we have acted on your point in some claims.

25 Now, I cannot be precise as to whether they were connected with asbestosis.

30 DR. MUSTARD: Let me take it a step further. Let us say that your rating is at twenty percent impairment, which is a mild impairment, let us say, and the person goes through it. Would the fact that they had a mild impairment lead you to feel that the bronchial pneumonia was less related to the chronic chest disease and more related to the other factor? Does that come into the reasoning at all?



5 THE WITNESS: It would really depend on the circumstances surrounding the case. I would have to answer that, in all sincerity and truthfully, that we might accept that, we might not. It simply would depend on the circumstances at the time, and we might conclude that the presence of a mild disease was cause enough for the pneumonia, even following the procedure, but we might not, Doctor.

10 DR. UFFEN: Just so I don't get lost, who is the 'we'? You say 'we might accept it, we might not'.

THE WITNESS: I'm talking of myself, Dr. Dyer.

DR. UFFEN: Independently, or in consultation?

THE WITNESS: Not necessarily. We might consult on a difficult claim, but...

15 DR. UFFEN: The two of you?

THE WITNESS: Yes. We might also send it to the committee, but we have in the past sent the committee cases like this - cases particularly involving death, but the case which you describe is rare, very rare.

20 DR. MUSTARD: Let me go back to the coronary heart disease, myocardial ischemia, problem.

We were both taught when we went to medical school, slightly different age groups, but still the same dogma, that thrombosis in a diseased artery was an important factor in causing the complication. Unfortunately, our profession has dogma.

25 Given that the underlying disease process in the arteries may well be contributed to by lifestyle and other factors, the precipitating event, however, that causes the blockage of the blood supply to the heart can be caused not only by thrombosis but by other factors. I guess we would have to accept the fact in the last fifteen years our understanding of the causality of the complication of the disease process, the heart attack, is not as clear-cut as what we were taught - that people who die suddenly



DR. MUSTARD: (cont'd.) with myocardial ischemia,  
usually do not show evidence of a collateral thrombus in the  
coronary arteries, and we now have the puzzle of sudden cardiac  
death in which the metabolism of the myocardium is important,  
as well as such things as the arteries going into spasm are  
important.

A case can be made that the degree of oxygen  
supply, etc., are important determinants of the susceptibility  
of the myocardium, and maybe the vasculature, in these events.

With that kind of evidence developing, how do you  
handle the question of chronic chest disease as possibly  
contributing or not contributing to the complication of the  
underlying arterial disease?

THE WITNESS: We have been concerned about this  
for years, and over ten years ago, twelve years ago, we requested  
the opinion of the chief cardiologist of Toronto Western Hospital,  
to comment on this business of the association between silicosis -  
that was the particular disease - and the risk for a subsequent  
myocardial infarction or coronary artery disease, and we  
received back, and the letter is on file, the report is on file,  
that from the opinion of this cardiologist there could be  
considered no connection - that one did not lead to the other,  
that the presence of pulmonary fibrosis would not lead to that.

Recently, two years ago, three years ago, we asked  
Professor Ritchie to go into this in detail for us...in a  
particular claim which was before the appeal board...or the appeal  
...yes, the appeal board...and he did so.

We have that document. It is attached to the file.  
It was his conclusion that you could not conclude that chronic  
chest disease, as a general diagnosis, would lead to an increase  
in the incidence of coronary artery disease or the incidence of  
infarction - that in fact some papers that have been published



5 THE WITNESS: (cont'd.) suggest the opposite, that the presence of chronic chest disease may in some way encourage the development of collaterals, particularly if there was some low-grade hypoxia, some slow-grade decrease of oxygen in the blood because of impaired diffusion and ventilation.

In other words, the suggestion was in fact the opposite - that those individuals with chronic chest disease, in the pure sense of the word, may even have had less.

10 So based on that, and based on our earlier opinion, we have generally not accepted a causal connection, you must know, unless there were some unusual circumstances, and once again it is the circumstances, unusual circumstances, that may cause us to deviate from that general direction.

15 There is no certainty that we will always keep to that direction, but as a general rule we have not, up to now, assumed connection.

DR. MUSTARD: Let's push this a bit further, because this is an area where there is enormous uncertainty.

20 Let us suppose that you could...and indeed I expect it can be done, that you can compile a group of experts, another group of expert witnesses, who would say that indeed the incidence may be less than people with chronic chest disease, but it's the frequency compared to another population with advanced coronary artery disease...and I'm now talking about the complications, I'm not talking about the underlying...

25 THE WITNESS: You are talking of the complications, right. I understand.

DR. MUSTARD: ...cause of the myocardial damage.

THE WITNESS: Right.

30 DR. MUSTARD: Let us suppose you have another group of experts say yes, that is indeed so, but the evidence about the effects of hypoxia on restricted blood supply to the myocardium



5 DR. MUSTARD: (cont'd.) is such that this could be an important determinant of causing the heart to go into an abnormal rhythm - that is, beat abnormally - and sudden death.

You can, as you know, take people and exercise them with an electrocardiogram monitoring them on their heart and show that you can precipitate arrhythmias if you have got borderline oxygen supply.

10 How would you handle the two different points of view?

15 THE WITNESS: I see the problem here - where is the hypoxia, where is diminution of oxygen to the heart muscle coming from? Is it coming from narrowed coronaries, or is it coming from impaired ventilation?

20 20 I believe that the study looked at the business of impaired ventilation resulting in impaired oxygenation of the blood, the decreased saturation, and looked at that effect on the heart, and as far as I can remember, impaired oxygenation or decreased oxygenation saturation arising out of pulmonary problems, but with intact coronaries, would not be enough to cause ischemia.

Now, if your ischemia comes from lack of blood supply to the coronary arteries per se, that's a different story.

25 DR. MUSTARD: Let's suppose I can...and indeed we could dig it up, but I don't want to get into the controversy of the technical aspects of it...let us suppose that you are presented with equally-strong documentation that diminishing the oxygen supply in the blood through decreased ventilation can now be shown, in people who have got impaired coronary artery supply, to diminish the oxygen supply to the heart, and if that person now exercises, the detection of an abnormal electrocardiogram is much more easily shown than if they have 30 a better oxygen supply in the blood stream - which indeed



DR. MUSTARD: (cont'd.) experimentally you can do.

Now, let's suppose you've got those two packages  
5 of information. How would you handle that?

THE WITNESS: I would say we would have to look  
at it very closely. Very much so. And we would certainly not...  
there would be a chance that we would recommend acceptance under  
those conditions.

10 DR. MUSTARD: Would you, in a circumstance like  
this, go to a broader panel of people to get a kind of a statement  
of the issue so that you could not be caught with any one  
particular view?

15 THE WITNESS: We might well refer that case to the  
advisory committee, because we send, not infrequently, if we have  
problems that are at that level or at the appeal level and reach  
the appeal level, we will send this for their opinion.

20 We also have requested the opinions of outside  
doctors, so any of those routes are possible in that case, and  
if an appeal body or an individual is not satisfied with our  
recommendation - Dr. Dyer's or myself - they are perfectly at  
liberty to request someone else, which we will arrange for them.

25 MR. LASKIN: Q. Could I just take you to Professor  
Barth's report for just a moment, before lunch? Can we go to  
page, first of all, page three point eight, and Professor Barth  
raises a few questions in relation to the manner in which these  
claims are dealt with, and the first question he raises is whether  
the Board receives adequate information regarding the circumstances  
surrounding a death.

THE WITNESS: A. No, not often. Not initially.  
We may have very little. We may have to seek it out.

30 Q. I take it you go behind the death certificate,  
as a matter of course, or are there occasions where you rely  
on what the death certificate says?



A. Rarely. We will most often go behind the death certificate.

Q. Then the second matter he refers to, and can I just...is this whole question of aggravation and so on, and in light of the dialogue you had with Dr. Mustard, can I ask you what your comment is on Professor Barth's observation - admittedly made not by the Doctor - which is that the concept of aggravation rarely seems to be employed in such decisions?

A. Once again, I'm trying to sort of remember... we are dealing with asbestosis and cancer and death supervenes, death...

Q. Dealing with asbestosis, partial permanent disability, death intervenes.

A. And death intervenes.

Well, we did discuss this generally, that with right-heart failure, okay, and...

Q. That's the only clear case, I take it?

A. It's clear, but there are other circumstances under which we would accept a death claim. I'm not trying to avoid your question, but it is so difficult to imagine even a hypothetical claim that you really have to go to the claim in question - see whether the circumstances are right and whether a man with ten percent or twenty percent award would have his death claim accepted.

It's not likely, but there are circumstances which would exist in which we might accept the claim.

Q. The Statute says, "Where death results from an injury", and what I'm trying to elicit, and my question isn't very clear, but what I'm trying to elicit from you is just what instruction you have received, or advice you have received, or what approach you have as to the kind of view you are taking of results of cause and effect.



A. All right. I understand your question. We have to be satisfied that the pulmonary disease in question was the major contributor to death.

Q. The major contributor?

A. Yes.

Q. Not just any contributor?

A. A meaningful contributor, significant contributor to death. I would not like to try to define it any further. Once again it's a judgement call.

DR. DUPRE: Can I just ask you, Dr. Stewart, where that interpretation comes from? Is this a directive that has come down to the medical services division from the corporate board, or what?

THE WITNESS: I believe we could interpret that from the Act itself, that...which implies that compensability is causation, and causation would have to exist whether it's for impairment or whether it's for death, and generally I think this is the kind of approach that we have taken.

I'm not sure that we can relate it to any single section of the Act, but just that it's understood that under our system there must be causation. The disease in question must be the principal cause of death, and I think that's the extent to which I can explain it.

MR. LASKIN: Q. Have you ever had a legal opinion on how to interpret section thirty-six...and I say 'you' as the Board?

THE WITNESS: A. I'm not aware of it.

Q. None has been communicated to you?

A. No.

MR. LASKIN: This might be a convenient time...

DR. DUPRE: Indeed, counsel.

Shall we rise until about quarter past?



THE INQUIRY RECESSED

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THE INQUIRY RESUMED

DR. DUPRE: May we come to order, please?  
Counsel?

MR. LASKIN: Thank you, Mr. Chairman.

10 MR. LASKIN: Q. Dr. Stewart, just to finish the discussion we were having before lunch, could I look with you briefly at page three point ten of Professor Barth's study, which is his table of rejected claims?

THE WITNESS: A. Yes.

15 Q. One observation which appears from just looking at the table is that apart from the case in 1979, all of the rest of the cases appear to have a rating of fifty percent or less, and should I be drawing any conclusions from that? Is there some rule of thumb, as it were, or guideline which would suggest that if you are somewhere between zero and fifty percent rating you die of something other than asbestosis, that basically you are not looking at a death claim? Or would I be drawing 20 the wrong conclusion?

A. I think you would. I think you would.

I know of no such direction on our part, no conscious, you know, approach like that, no presumption like that, no prejudice that before such a claim is...

25 Q. Do you know of some claims where the rating has been between zero and fifty percent and there have been granted death benefits?

A. I believe there are, but I really, once again, I cannot...I cannot say. I must confess to you, I can't say. It's possible, of course, as I said before.

30 Q. Just to take the right-sided heart failure case



Q. (cont'd.) for a moment, would the percentage rating have any bearing on whether you grant a death benefit in that kind of case?

A. If you had ten percent and died of cor pulmonale, we might assume that there is secondary disease present, not associated with the asbestos.

Now, I would think that a case like that would be sent to the committee for their opinion. I do not recall a case in which there has been ten percent and the man has died of cor pulmonale. It's possible, but once again I must take refuge in the claim that each case is different and it might not be accepted - chances are it would not be - but it could be.

I cannot remember such an example, however, as you have just given.

DR. DUPRE: I just want to go back to a question you asked, counsel, with respect to the fact that all of the claims on that table, with one exception, were claims where the individual is rated at fifty percent or less.

When I run over to table seven, to the extent that it is used here...

MR. LASKIN: Page six point eleven?

DR. DUPRE: Page six point eleven.

That table certainly seems to indicate that the overwhelming majority of at least initial ratings of asbestosis claims, overwhelming majority, involve fifty percent disability or less, and just looking at the table, in any event, statistically you would expect the same kind of proportion, I think, on the table you were looking at.

However, maybe Dr. Stewart can help me a little bit more in terms of understanding Professor Barth's other cases.

They are tables based on WCB data that purport to show rating changes.



THE WITNESS: Yes.

DR. DUPRE: Dr. Stewart, the general impression I  
5 get from reading table ten is that even where rating changes are concerned, not many rating changes tend to bring asbestotics above fifty percent. Would that be a correct impression to derive from that table?

10 THE WITNESS: It would, but not by intent. It may well be and is that the diagnosis is made very early on now, and that the progression simply may not be as great as some people may perceive it should be or is.

There is no doubt that we have asbestotics who are in the upper ranges and are in eighty, a hundred percent range.

15 I can't read anything from this table beyond it, really. I don't think you can conclude that we don't have a fair representation in the upper ranges, although it may be a lot less than you would expect because initially they are got early.

20 DR. DUPRE: Let me ask you this. This is a statistic that I have not found in Barth, although perhaps it is in here somewhere. Among the death claims in which asbestosis was the cause of death, what was the percentage rating of the deceased, for partial disability purposes, on the event of his demise?

25 THE WITNESS: It would likely be fairly high if it was not due to a cancer.

DR. DUPRE: Right. Indeed, I'm thinking of indeed what would be medically called...I believe the term is used - death from asbestosis.

30 THE WITNESS: I can answer you that it would not have to be a hundred percent. I'm not trying to avoid your question. I simply can't answer it by recalling the exact numbers, but it wouldn't have to be a hundred percent. All it would have to be



THE WITNESS: (cont'd.) would be that the asbestosis clearly was a major contributor to death.

I would have to get to the claims and see.

DR. DUPRE: Can I ask you this? In the event of a situation where you have an asbestotic with a partial disability pension, and he is hospitalized in the weeks or months that precede his death, is that individual, during his hospitalization, given a temporary total disability pension?

THE WITNESS: If the hospitalization was due, in our opinion, to complications from the asbestosis, he would get this temporary total disability during this hospitalization.

If his hospitalization was due to something else, he might not.

DR. DUPRE: The chances are, I suppose, that an individual who dies of asbestosis, in hospital, would probably, at the time of his death, have had a combination of partial disability and temporary total?

THE WITNESS: I wish...I can't say. He is either in hospital because of his disability, or he is not. There is an in between where it may be difficult to decide.

Obviously, a judgement call is made here and a recommendation made by the medical to the claims department...if this question is asked of us by the claims department. And they will generally do that, they will ask us.

As long as we feel that there is a reasonable connection between the cause of the hospitalization and his disease, we will recommend that he be considered temporarily totally disabled.

Once again, I'm sorry I cannot give you assurances on a specific claim. It would have to be according to the circumstances of the claim.

DR. DUPRE: Can I ask you this? Are temporary



DR. DUPRE: (cont'd.) total disability benefits ever retroactive? I'm thinking simply of a situation where an asbestotic with partial disability is hospitalized, dies in hospital, and the cause of death is unambiguously asbestosis. Can there be a temporary total disability pension paid retroactively to cover the time in which he was hospitalized?

THE WITNESS: Absolutely. We are often, not infrequently we are asked this question by the claims department... not necessarily just with asbestosis, but with other pulmonary claims, and we most generally recommend this right back to the time that the individual became totally disabled, which for all intents and purposes is when he enters hospital.

He may have even become disabled before that. In this case we will recommend retroactivity to the time, prior to the hospitalization.

DR. UFFEN: Well, I wanted to go back a bit to when you...we were talking about table one on page three, ten of Barth. This was the death claims rejected where pension had been granted for asbestosis.

The first question, one of information, it says, "cause of death". Is that the cause of death listed on the death certificate, or is it the cause of death determined by somebody else?

THE WITNESS: I wish I knew what he meant.

DR. UFFEN: Oh, all right. Maybe we should try to find that out, because...let me put it another way. Is it possible that it might be different if it was from the death certificate?

THE WITNESS: Yes. I would not be confident that those causes of death were accurate unless I saw each of those claims and I could look over each one.



DR. UFFEN: Now, which would the Board, the Workmen's Compensation Board, use - the death certificate or the cause of death as determined by the medical people like you within the Board?

THE WITNESS: We would use our own...

DR. UFFEN: You would use your own?

THE WITNESS: Yes.

DR. UFFEN: So for a layman outside, it's not surprising that we have a little difficulty in appreciating that a death certificate can be wrong. Now, I got a terrible shock eighteen months ago when I discovered that Dr. Selikoff was quoted as having said that something like fifteen percent of them were wrong.

THE WITNESS: Well, I think there are more than that.

DR. UFFEN: More than that? Okay. Well, that could be cleared up.

Now, another thing. I'm not sure I can put my finger on it in Dr. Barth here, but referring to British Columbia policy where I think the Workmen's Compensation Board in British Columbia presumes that death related to lungs or heart would automatically be presumed to be...for an asbestos-compensated person...automatically decide in his favor.

If we were in British Columbia, I see one bronchial, myocardial, bronchial...I'll skip the next...a multiple cardiac pulmonary, a coronary occlusion...I'm not sure about the next...a myocardial infarction...is an infarction a blood clot? Is that what they call a blood clot?

THE WITNESS: I understand it as the death of a part of a muscle.

DR. UFFEN: Oh, okay.

The point I'm getting at, it looks to me like something like half of those cases in British Columbia would not



DR. UFFEN: (cont'd.) have been interpreted the way they are in Ontario.

5 THE WITNESS: It seems that way. It seems that way.

DR. UFFEN: Okay. I understand it, then.  
Thanks.

MR. LASKIN: Q. Just one question on the appeals structure in these claims, just to complete the picture.

10 To the extent that there were any appeals from the denial of survivor benefits, would I be safe in drawing the same conclusion with respect to those appeals as your evidence appeared to be in respect of appeals on straight asbestosis or straight cancer claims? That is, that a different decision by the appeal body would be a rare occurrence, if indeed it did occur?

15 THE WITNESS: I'm trying to remember cases in which this has occurred. I just remind you I would refer such a case from the appeal level, if requested, and I would, on my own, to our advisory committee. I might also refer it to Professor Ritchie. I might also refer it to our chest disease consultant who works with us four days a week now, four half days a week - Dr. Cameron Gray. Besides being a member of the advisory committee, he spends four half days a week at the Board, advising us and consulting with us on difficult claims.

20 I think that we...he has been doing this now for two years and we inevitably will end up by discussing such a claim with him, so we have those three areas in which we would not... and we might also, at the request of the appeal body, send it out to another physician outside.

25 But insofar as the numbers of changes are concerned, consequent to this reassessment by those three parties, they are so few I don't think you would have many changes.



5 THE WITNESS: (cont'd.) I must tell you that we try to work up a claim and we try to be as thorough as possible in the initial stages, before we present an opinion either to the claims department or to the appeal board, and we would not expect many changes based on this care that we think we take.

Q. Fair enough.

You mentioned Dr. Gray being a consultant?

10 A. Yes.

Q. To?

15 A. He has been under contract to the Board, to assist us in the pulmonary field on a basis of four half days a week. He comes to the Board and sits in an office and we give him claims that we are uncertain of, we have difficulty with - principally appeals in chest disease, various forms of chest disease.

20 Now, he might not see a claim in which the advisory committee was previously involved, and we might simply send it to the committee as a whole, rather than to send it to him when he was at the Board.

25 But in other claims in which he is not directly involved with the committee, then of course he will be able to take a direct action.

Q. Would a claim, an asbestosis claim, could it go from you to Dr. Gray, and then to the advisory committee?

30 A. No. I would more likely send it directly to the advisory committee.

Q. Where he also sits?

A. Where he also sits.

DR. UFFEN: There is a third person, Dr. Muir, who is labelled consultant, I believe. Is there a similar exercise involving Dr. Muir?



THE WITNESS: No, he is in Hamilton, so we don't...  
no, we do not use him in that way. He does examine Board  
5 pensioners with asbestosis, that may be coming up for reassessment,  
and if they live in the Hamilton area, he may see them there.

We have not referred, to my knowledge, a contentious  
claim to him, outside of this area...that is sent to us from the  
appeal level.

10 MR. LASKIN: Q. Can I ask you just...I'm just going  
to change to a different topic, and can I ask you this one question  
about the lung cancer claims, just so I have it straight?

I take it that if a lung cancer claim fits within  
the guidelines for compensation, it is compensated and whether  
or not the claimant smoked or didn't smoke is irrelevant?

15 THE WITNESS: A. Absolutely.

Q. Then I take it also from reading Professor  
Barth, that there is a second class of claims that is automatically  
accepted, though not so stated in the guidelines, and that's the  
claim for lung cancer where there is also co-existing asbestosis?

A. That is also true.

20 Q. Then the other claims that don't meet either  
of those two categories are judged individually?

A. Yes.

25 Q. Okay. And the question I have for you, but  
I wasn't clear from reading Professor Barth or the guidelines, in  
those cases which are judged individually, does smoking play a  
role? Is it taken into account?

A. No, we do not take smoking into account,  
simply because the population from which those people come  
are all smokers, and we compare that particular claim and the  
circumstances surrounding that claim that doesn't fall automatically  
30 within the guidelines, to a person that does fall within the



5 A. (cont'd.) guidelines. They are both smokers, so we end up by looking at the exposure as the primary determinant, provided the diagnosis has been confirmed.

We do not take into consideration smoking in a person who automatically gets accepted, so we certainly...we do not...so we approach the claimant that is not automatically accepted in the same way.

10 Q. I wanted to turn, finally, to the special rehabilitation assistance program.

A. Yes.

Q. And your involvement in that program.

Now, did you receive at some stage, in 1976, some instructions or directive to establish that program at Johns-Manville?

15 A. Yes. I received a memo, or the medical branch received a memo, from the chief claims officer that they would like to see the special program in Elliott Lake introduced at Johns-Manville.

20 Q. Were you asked to set up the program?

A. I was asked to participate in the team and to help in setting the program up.

Q. Who was the team?

25 A. The team consisted of representatives from the rehab branch, and the claims branch, and if you ask me the number and their names, I'm afraid I might just have precisely forgotten. But there were three or four nonmedical personnel with the team.

I'm sorry my memory is bad, but...

Q. That's fine, Dr. Stewart.

30 Can I ask you to look at, again, Professor Barth's report with us for a moment, and I know you have read the particular chapter in this report that deals with it - which



Q. (cont'd.) is chapter eight.

A. Page?

Q. Can we start at page eight point two?

A. Yes.

Q. May I ask first of all, were you consulted in advance of receiving this directive from the claims department? Were you consulted in advance as to the advisability of such a program?

A. I don't remember a formal consultation in this regard. All I remember, as a member of the Board it was expected that we would do our best and that we would try our best.

No, I wasn't specifically asked whether it was feasible or desirable. It was asked of us just simply to go ahead, use our experience with Elliott Lake.

Q. At the bottom of page eight point two, Barth makes the statement:

"Regardless of whether or not this announcement"... the announcement of the program..."was pre-emptive, many of the staff at the WCB believe it to have been the product of political expediency rather than sound medical considerations".

Then in the next paragraph, it goes on to say:

"A primary source of objection to the SRAP came from the medical services division of the WCB. The roots of these criticisms were and continue to be certain basic medical issues"...which he then goes on to elaborate.

Has Professor Barth fairly stated the situation there?

A. First of all, there is no doubt that there was considerable pressure and considerable media involvement of



5 A. (cont'd.) Johns-Manville at the time, and it was expected that something should be done. It was perceived that something should be done about Johns-Manville, and the special program was the vehicle which was elected and which was selected to do that job.

10 As to the mechanism of the pressures that were involved in this, and that produced the instruction from our superiors to go ahead, I can't really say. But I do remember it was pretty volatile around that time.

15 To the government, to them it seemed reasonable that something should be done, and it was high profile in the Legislature, no doubt.

20 Now, as to our thoughts about the matter, I don't think that really mattered at the time what we thought. I think many had private thoughts, but we could not...we could not ignore what was going on around us, and realized that the initiative and the pressure for the special program came from the Legislature, from government, from the opposition. We knew that.

25 But this does not gainsay the fact that we, as members of the Board, had a duty to try to do something - even though some of us may have had some reservations about the efficacy, about the worth of the program.

Q. Were you one of those people?

30 A. I would say that at that time I had my reservations, but I did not formally present them to the Board, or object, and what Professor Barth is saying is post hoc, it's after the fact in many ways, and looking back, yes, we had some reservations and the difficulties that we encountered in it, of course, seemed to - in retrospect - underly those reservations.

But the fact remains that we expected, were



A. (cont'd.) expected and expected to carry out what we were asked to do.

5 I don't know if I can put it in any other way.

Q. Can I just ask you, in terms of the reservations that you yourself had at the time, although you may not have expressed them to anyone, does nonetheless Professor Barth capture those reservations at page eight point three?

10 A. Let me just have a look at this.

Let us say that there is a thread of truth in what he says, although it is more apparent to us now than it was then.

15 In 1976, we were aware of the limitations in withdrawing someone from exposure where that exposure was fractional, compared to previous exposure, and we were aware of the criticism of the Royal Commission on the Health and Safety of Workers in Mines, in this respect, where we attempted to carry out the same principle - that is, taking a person out of exposure who had accumulated a certain amount of risk that would not necessarily decrease if he stopped exposure. We 20 were explicitly criticized for this in respect to radiation.

We suggested, in Elliott Lake, that a certain designated cumulative radiation be set, and beyond that - withdrawal from exposure. The Commission said in effect that what you are doing simply is withdrawing someone from exposure where the risk will not decrease and where the manifestations of the risk may well appear, regardless of whether you withdraw 25 that person.

At the same time, you ask someone else to go into exposure and you spread additional risk around.

So we were aware of this, and there is a certain similarity between the risk that is cumulative in radiation and that cumulative in asbestos. In both, neither risk really



A. (cont'd.) decreases once exposure ceases, the latency periods are long, and you expose other people.

5 So there was a certain analogy, a certain comparison there. So those were some reservations we had.

You could equally apply that to whether there was frank disease or incipient disease. In both there is a retained risk. It does not decrease once exposure ceases. It doesn't decrease significantly.

10 DR. UFFEN: Does it increase if exposure continues?

THE WITNESS: It all depends on the incremental exposure, and the Royal Commission decided that the incremental exposure in Elliott Lake was not a reason to withdraw a person who had accumulated one hundred and twenty working-level months of radiation exposure. That's the way they described that exposure.

15 The incremental exposure in those days was possibly a fifth, a half, possibly less, of the exposure in prior years.

In other words, there was a decrease in it.

20 When we got to Johns-Manville, the fractional decrease in exposure was fifty or a hundred times the exposure that occurred in prior years, so we had to think whether this was a reasonable, practical thing to do.

25 If an individual has worked in asbestos, and say has accumulated a hundred, two hundred or three hundred fiber cc years, and continues in exposure where the exposure is zero point one, zero point five, zero point three, he would have to work a long, long time to add significantly to his cumulative exposure. If he worked five years at zero point one, zero point five, point five or two point five fibers added onto two hundred is simply not, in any logical way, going to affect any existing disease, will influence his risk in the future for a disease that may appear, or will certainly help his health in



A. (cont'd.) any way.

5 So in that sense, we had to wonder about the justification for it. But while we might have wondered about that, it might have gone through our heads or my head, we nevertheless had to do what we were asked to do and requested to do, and we had to fit the program in in the best way possible - by taking cognizance of the reduction in the overall exposure that we encountered in 1976 and 1977, as compared to the  
10 historical levels.

MR. LASKIN: Q. Have you read the rest of this chapter, in particular the critique that Professor Barth offers on the program itself?

15 THE WITNESS: A. I have. Are there any particular...

Q. Well, can I ask you in a general way, firstly, is it a fair critique? Is it a fair description of the program and what went wrong with the program?

20 A. Well, it's a pretty general question. Are there any specific aspects of it that...no?

Q. Sure.

He makes a couple of points at page eight point five. The first point that he makes is of the deterioration in relationships between the union leadership on the one side and the WCB staff on the other, who were responsible for implementing the program.

25 A. Well, the union leadership at that time felt that all persons who showed signs of asbestos fiber dust effect or asbestos should be put in the program, and we didn't agree. So that obviously was a cause for resentment.

Q. What was the Board's position on that?

30 A. In respect...?

Q. As to who should be in the program. You said



Q. (cont'd.) your position was that not all...

5 A. All right. First of all, the decision had to be made as to what areas, if any, of the plant would be considered habitable, would be considered of low enough exposure as to be compatible with continued work, for those people.

Now, I was the one who had to advise the Board as to what areas they should consider, if any, in this way.

10 In 1976, when we started to interview people, we had not yet determined...I had not yet determined, in my judgement, what areas I felt were suitable alternative work areas for people who might have been in exposure in some other part of the plant.

15 You must remember at Elliott Lake the key to the success of the special program is alternative work being found within the industry concerned. Only to a limited extent did we find that relocation or retraining was the alternative selected.

Then the success of the rehabilitation part of the program depended on a reasonable...an area of work that could be selected by those who were affected, who might have been still in exposure in another area, so that they could work there.

20 Now, we waited for six or more months for a new set of dust samples results to be taken by the occupational health branch, and when we got them, around January of 1977, it was my opinion, and I made a recommendation to the Board, that the only area which would seem to be of even remotely hazardous would be the transite pipe production.

25 In my opinion, the other areas of the plant, particularly the transite pipe shipping and receiving area, were suitable places to work for people who had been affected. The reduction in exposure was immense, compared to past exposures at the plant, judging by the results that were given to us at that time.

30 Much of the work in transite pipe shipping and



A. (cont'd.) receiving was done outside, some inside, and the range of fiber counts there, according the 1977 results, 5 ranged from not detectable to zero point one fiber, zero point three, zero point five fibers - mostly under zero point five fibers.

To a person who had two hundred fiber cc years, I 10 felt that this was a reasonable place for him to work, particularly since in many cases he had not much time to go since he was near retirement - many were, this was an older population than those we encountered in Elliott Lake. Some had a few years to go, some 15 had not many years to go, so it was based purely on my recommendation that the program went along those lines, that the only area which we would accept candidates from would be the transite pipe production. We would not...we would elect, we would consider that thermobestos area, we would consider that the fiber glass area was suitable alternative work sites for people who were working and who had been affected in the transite pipe, and this was a judgement recommendation by myself, which the Board accepted, and which not everybody agreed with, in the union.

Q. Is Professor Barth correct that the program as 20 initially contemplated was to provide benefits up to one year only?

A. Yes, this is true. This was changed later on.

Q. Did that initial factor also play any role in the...

A. Yes, I think it did. I think it did.

Q. When all was said at done at the end of the day, 25 Professor Barth makes the observation that perhaps the most striking outcome of the program was the small-scale nature of its effort. Is that fair?

A. Well, it was a large-scale effort on our part, believe me. But the results, if you look at the results by the numbers I don't know if you can necessarily come to that sort of a conclusion. It was a voluntary program. Some people elected not to



5 A. (cont'd.) go on because they didn't necessarily like the terms. That was not because necessarily that only the  
transite pipe was selected, simply because there wasn't an absolute assurance that once you went on the program that you would be successful in obtaining a job or that it would be an indefinite contract. It was very difficult in those days just to find alternative work for individuals who were in their fifties, some were sixties, who had no other skills other than what they learned in the plant,  
10 and it was a problem.

Q. I take it that was much less of a problem with the Elliott Lake program?

A. Yes. Yes, much less.

15 Q. Was that because, number one, the age distribution...

A. Yes.

Q. ...of the employees?

A. Yes. There was at least an average ten year.. the mean average age was less by ten years in Elliott Lake.

20 Q. Secondly, the greater opportunity for available employment within the mining industry up there?

A. Yes.

Q. Any other factors? I'm just trying to focus on why it would appear at Elliott Lake, on its surface, in any event, reading about it, appear to be more successful than...

25 A. Well, because when a person goes from underground to surface, you presume there is no exposure, that it is a perception - there is no exposure in surface jobs. It's an absolute decrease in exposure, although it's not strictly true.

30 The reduction in exposure experienced by a miner as he goes from underground to surface may be substantial, but not absolute. There is always quartz dust around, but generally of a low order. We must not forget, too, that one of the underlying planks



5 A. (cont'd.) of the special program in its conception was the acceptance that...of low-exposure alternatives. It was clear in the ministerial announcement that preceded this program, the Elliott Lake program and the construction of it, that low exposure alternatives were part of the program.

10 In other words, if I may just illustrate - a man who worked in Elliott Lake, who showed some signs of dust effects, it was felt that he could go, say, to Sudbury and work underground without any problem. So that there was never, from the start, the necessity that there be an absolute lack of exposure in the alternative job location, and a percentage reduction in the exposure experienced by a man from Elliott Lake, that might have gone to Sudbury, was far less than that experienced by a Johns-Manville employee who was offered a job in the transite pipe shipping and receiving.

15

DR. UFFEN: The exposure to radiation as well as dust, does it play any part? For instance, you've been talking about the silicosis and the dust at Elliott Lake.

20 THE WITNESS: Yes.

DR. UFFEN: What about the role of the alpha particle and radon gas and things like that? Was that not part of it?

25 THE WITNESS: Well...but they were separate and would not be considered together in any synergistic way.

DR. UFFEN: I understand that. You made that point this morning. But let me try this on you to see if I'm....if I'm a miner working underground in a uranium mine, I get exposed to dust and radiation.

THE WITNESS: Yes.

30 DR. UFFEN: I can get out of the dust by cleaning up the apparatus or getting out the mine. I can't get out of the radiation unless I get out of the mine.



THE WITNESS: You go to surface.

DR. UFFEN: That's what I mean, go to the surface.

5 You can't stop the radiation, so a miner who felt that he was accumulating exposure of two kinds - radiation exposure and dust exposure - by going to the surface and taking other work would be avoiding these two kinds of risks, even if they weren't synergistic.

10 THE WITNESS: Except that he might not derive any benefit from avoiding further exposure to radiation, in the terms...

15 DR. UFFEN: Now this is what...I can see he might not derive any benefits from further exposure to dust. Can you explain to me why he would not derive benefit from avoiding further exposure to radiation?

20 THE WITNESS: I think it's just the opposite. I really feel that he would derive benefit, likely to derive more benefit from getting out of high quartz..a high-quartz atmosphere than he would getting out of an atmosphere in which he had accumulated a hundred...say a certain amount of radiation, where the radiation was much reduced.

25 DR. UFFEN: That's the point - where the radiation was much reduced. The only way you can get out of it is to get out of the mine.

30 THE WITNESS: It was reduced...it would have been much reduced underground.

DR. UFFEN: Underground? Oh. In what way?

35 THE WITNESS: Well, there was an improvement in... there was a fairly great improvement in the radiation conditions underground, by 1976, say as compared to the years in the late-fifties when they first...

DR. UFFEN: Was it clothing they wore, or...

40 THE WITNESS: No, simply by the dust-control ventilation.

Dust was also reduced, but not to the same extent,



THE WITNESS: (cont'd.) the same proportion.

Dust conditions in 1975, in Elliott Lake, were  
5 about half those that existed in 1958, 1959...one half.

Radiation conditions that were...were reduced by...  
well, could have been reduced by five or ten. So there was a bigger  
reduction.

But I did say to you that we were criticized by the  
10 Royal Commission for doing this, for approaching the problem of  
radiation in that way - by taking someone out where the radiation  
had been much reduced and where it was not likely that his  
additional increment of radiation would influence his health in  
any way, either...

DR. UFFEN: Just going back to the reason why the  
15 Elliott Lake program appeared to have worked, at least better than  
Johns-Manville, from the perception of the miner who may not be  
expected to understand the niceties of synergism between radiation  
and dust, he's got a double chance if he gets the hell out of the  
mine - he is not getting exposed to dust or radiation - so put  
simply, he might figure it's twice as appealing.

20 THE WITNESS: I agree with you that that was a  
perception at the time, that this was a dual exposure, this was  
dual risk.

I think there were far more jobs available and they  
25 were younger people. They were more flexible in their ability to  
adapt to new jobs on the surface.

MR. LASKIN: Q. In the light of your experience  
at Elliott Lake and then with the Johns-Manville program, have  
you got any guidance, counsel, for us on how worthwhile these  
programs are and whether a compensation agency should be considering  
undertaking these kinds of programs?

30 THE WITNESS: A. I think you have to look at it from  
two ways. You have to look at it from a health benefit point of



5 A. (cont'd.) view. You have to look at it from  
a...how do we say it...psychic point of view, a mental point of  
view. If a man has perceived he is under risk and feels he must  
leave, I suppose there is a reason there to think about that, and  
that is sort of a...but that is not distinctly a medical consideration  
in that sense. It is a consideration for the administrators, for  
politicians.

10 In respect to medical input in this kind of a program,  
we are obliged to point out to our superiors that degree of health  
benefit that might be expected to result from it. But based on  
this, they can formulate their policies. If they choose to disregard  
our assessment of it, that's fine.

15 But if we were to follow the basic requirements of  
the special program as it was conceived by the ...as it was  
conceived and as it was promulgated in Elliott Lake, and if we  
are to have...pay some heed to the admonitions of the Royal  
Commission, then we have to point out these limitations, from a  
health point of view, to our superiors.

20 It does not mean that we would not be expected to  
go ahead and do what we can.

MR. LASKIN: Q. I take it on the health effects  
side, looking at it in 1982, do I put it fairly that the evidence  
is still very unclear as to the benefits, if any, of removal?

25 THE WITNESS: A. It isn't clear. But I do agree  
with John McDonald when he says if we did help one person, it's  
worth it.

I think we have to look at it that way.

Q. Though you may never know one way or the  
other?

30 A. We may not know. We would like to. I don't  
know.

DR. DUPRE: Just to follow up on that, can I just



5 DR. DUPRE: (cont'd.) first of all go to table nineteen on page eight, nine and eight, ten? This is a table in Professor Barth's study that I understand is not his table. It is indeed the WCB table on the SRAP program?

THE WITNESS: Yes.

10 DR. DUPRE: First of all, let me just turn to page eight, ten. Is the so-called...what I would call the bottom line figure of the whole thing...is that the figure that appears next to two (a) - namely, eighteen individuals out of exposure, participating and receiving TPD, or pension, or combination?

15 THE WITNESS: I believe that's correct, at that time.

DR. DUPRE: That is the bottom line in terms of eighteen who wound up participating.

Now, can I ask you the following: I don't understand two (c) - 'off due to noncompensable reasons'. Is that eight out of the eighteen, or is that another eight?

20 As always, on page eight, ten.

THE WITNESS: Right.

25 DR. DUPRE: Next to two (a), we've got eighteen.

THE WITNESS: Right.

Mr. Commissioner, I must tell you that I think the rehabilitation department would be in a much better position to explain.

25 DR. DUPRE: Okay. Let's leave it that way.

But is it fair for me at least to take away for the moment that there were eighteen individuals who did wind up for the...

THE WITNESS: I think that's true. I hope I'm saying I'm right.

30 DR. DUPRE: Let me ask you this: Have you been



5 DR. DUPRE: (cont'd.) able to ascertain, simply in terms of at least whatever claims you may have been getting since the program, how these individuals have fared? You know, have you gotten claims for partial disability due to asbestosis out of this population? Have you had any death claims arising from asbestos-related illnesses?

10 THE WITNESS: It's my understanding that there has been some considerable change in that respect, and that once again I know that you will be able to be enlightened by...

DR. DUPRE: Your understanding was that these eighteen have fared relatively well in terms of not coming down with compensable...

15 THE WITNESS: Oh, I'm not talking...I can't be sure of the eighteen. I'm talking of the whole group that we interviewed, that there have been men who have died, I believe, and who have got ill since that time.

20 As far as the eighteen are concerned, I'm sorry I cannot give you...that will have to come from the rehabilitation branch.

25 DR. DUPRE: Okay. Then I'll certainly pursue it with them.

DR. UFFEN: One other question in a different area altogether. I think I had better wait until you...

MR. LASKIN: I actually had just about one or two more questions, and really let me just pose the final area I wanted to ask you about.

It comes from a statement that I find in Professor Eissen's critique, amongst others, and I don't know whether you have had an opportunity to read that critique or not.

30 THE WITNESS: A. I have, yes.

Q. I am really trying to draw on your long



Q. (cont'd.) experience both in the industrial disease field and in the compensation field. The statement he makes is that...first of all, he says,

"A crucial measure of the success of any compensation system would surely be the extent to which disabilities from occupational disease are recognized as such, and compensated to the extent that compensation is lawfully due".

And then he goes on to say his belief that there is a cause for concern that the incidence of industrial disease is probably much greater than might appear from the statistics of compensation claims.

I wonder if both in the general sense and more specifically in respect of asbestos claims, you yourself, in your own considerable experience in the field, can you give us any sense or feel for whether his observation has some truth to it?

A. Oh, I think his observation has some truth to it. But if, as we have heard, physicians are not very knowledgeable about occupational disease, and say asbestos, they may well be missing cases, and it is as reasonable to give his view credibility as it is to say they are not.

I think that I could not refute it. It's quite possible that what he says is true, but I have no way of, you know, quantifying it, of assigning an estimate to the degree of it, and I think we just have to judge that probably there are.

Whether there are a great number, I don't know. But I think there are some cases out there that are not being detected, simply because the physicians are not knowledgeable in the field.

DR. MUSTARD: I just might comment on that, if I might, that, as I said earlier, if you take the Sir Richard Doll/Peto estimates in the United States, for occupationally-induced cancers,



DR. MUSTARD: (cont'd.) and apply that figure to  
the mortality from cancer in the Province of Ontario, you would  
5 expect, if you can approximate that four percent figure in Ontario,  
that there would have been about six hundred claims of  
occupationally-induced cancer per year over the last two years, and  
I gather the number of claims are about sixty. So it's about  
one-tenth of what you would expect.

10 Now, it may be that our work environment is totally  
different, but I think that you identified something which is  
extremely important, and that is the question of the quality of  
the observations being made by physicians out there, and overall  
awareness of the issue.

15 I guess the thing that I would like to ask you a  
question about, recognizing that, have you ever given thought to  
the kind of information base that maybe should be maintained  
for the work force so that in an ideal world you would be fairly  
easily be able to get at the association between exposure and  
cancer?

20 THE WITNESS: I have given thought to it, because  
we have the framework of such a data bank with our miners, and  
we have kept it for many years.

We have exposure, duration exposure and x-ray  
rating, and that is on file. That is there. It's retrievable.

A person who worked in 1935, we can retrieve.

25 The trouble is, it does not exist in any other area  
of occupational disease because industry or government did not  
establish a data bank as they did for the mines, and it does seem  
reasonable that a similar setup be set up for surface industries.  
I think it would be an enormous job, and take an enormous amount of  
co-ordination between industry and government. I don't think that  
30 either could do it alone.

But the direction of this seems to be away, however,



5 THE WITNESS: (cont'd.) from that, in that government now is tending to let private industry do the pre-employments and do the medical assessments, and keep records. This is the direction of the new legislation. It's going in the opposite way. One cannot be sure that the information that is accumulated in private offices or clinics will be kept or get to the central source.

10 This is an opinion, and might be an unpopular opinion with government, but I feel that something like our mining nominal roll system and our statistical system is probably a good example of what should be done. But the trend is away from that.

Screening is now much decreased, and it's put into private hands, or it may be put into private hands.

15 DR. UFFEN: Maybe that question I had in mind is appropriate here.

What does this chap D. Saunders do, who is industrial disease research specialist? He is in your division.

20 THE WITNESS: Yes. He aids the industrial disease specialists such as those dealing with asthma and with the toxic claims that involve toxins of various sorts. He is involved deeply in organizing their data, setting up a card index system and searching the literature, at our request, for subjects that we wish to be knowledgeable on or we wish to be apprised of.

DR. UFFEN: Would he have the type of training and qualifications to initiate what Dr. Mustard had in mind?

25 THE WITNESS: I would think that this would lie in his area, that it...it is an enormous job, however. The implications of it are very large.

MR. LASKIN: Q. I just have one final question, and again it's a very general question, Dr. Stewart, which again tries to draw on your experience at the Board.

30 The question is really this: Do you or does the Board have any sense of the kind of disease compensation picture that



5 Q. (cont'd.) you are looking at in the next decade  
insofar as asbestos-related claims are concerned?

10 A. What is my perception of how it is going to  
evolve?

Q. Yes.

15 A. I think we are going to see a lot less  
asbestosis, and we will continue to see the cancers for the next  
ten or twenty years.

20 DR. MUSTARD: Can I just follow up on that in a  
slightly different tangent? It's in section six in the Barth  
document, where he had all the tables about claims accepted and  
claims denied.

25 But in it is the comment that, of course, if a claim is  
denied you may see it again, one, two or three years down the  
road and then it may be accepted at that time. It was very  
specifically for asbestosis. I can't put a handle on a table that  
will guide me easily through this.

30 But I was wondering, do you have somewhere a running  
account of the asbestosis story in relation to the work force in  
Ontario, that is exposed to asbestos fibers, in which you can get a  
feel for what proportion of that work force manifest asbestosis?  
I'm going back to the discussion we had earlier this morning about  
when the criteria for the diagnosis become positive, recognizing  
the sensitivity question, one would sort of expect on biological  
principles that people who initially are negative, some of them  
would become positive and that's in there, and I would be interested  
to know what proportion that really represents of the total group.

I would also be interested in knowing whether the  
number that's being denied now is increasing compared to the past,  
and whether the frequency with which they are becoming positive is  
increasing or is becoming less, so I guess what I'm trying to get  
at is that if a thousand of us were exposed to asbestos fibers, even



DR. MUSTARD: (cont'd.) an equal amount, because of our host variability some of us would manifest it soon and some later, and some of us would not manifest it at all.

I know I'm not being very clear about that. Do you have any feel for what the pattern is in terms of...

THE WITNESS: A trend?

DR. MUSTARD: The trend, on all those conditions - the denied claim, denied claims becoming positive, etc.

THE WITNESS: First of all, one of the problems that we have always had in Ontario is that we have never had a proper population base with which to develop statistics. We know roughly how many people are working in asbestos in the province at any one time, but we have not been able to use this because we haven't had their names.

We haven't broken it down, necessarily, into categories.

Now, if you wanted to know the trend in insulation, the trend in brake linings, the trend in textiles, or the trend in construction, this is what you want to know - the incidence and the prevalence and what was it like years ago, what is it like now.

We would like to know that, but we don't have that precise information.

As far as your other points are concerned about whether a person now who shows no signs, what chance there will be for that person to become positive in the future, I wish I...I don't really think I can answer it. It's a question that we could address ourselves to, try to develop a program to get the answers from it, but we have not directly done this so we cannot say. We can speculate on rough trends, and I think that the trend is that the asbestosis, the degree of asbestosis we are seeing now is less than it was five or ten years ago. But it's still a little early yet, even for asbestosis, because there is a long delay period and the



5 THE WITNESS: (cont'd.) greatest exposure occurred in the fifties and the sixties. So we still have a fair amount of latency to go before we can say with certainty.

10 I wish I could really answer your question directly. It's something that we would have to work on. We would have to look at our statistics and our figures. We would have to go back to old cases, take these claims allowed and break them down, see what has happened to them. I really...I wish I could answer your question better than that.

15 DR. MUSTARD: Can I ask a different question? I would take it that it is probably easy to have the whole work force of the Johns-Manville plant for the last thirty years - that's accessible to you?

15 THE WITNESS: Yes.

DR. MUSTARD: As far as your organization is concerned, is there a systematic tracking of that work force and what happens to them in terms of asbestosis?

20 THE WITNESS: No. They are tracked by the occupational health branch or the chest disease service while they are working, of course.

DR. MUSTARD: But if they stop working?

THE WITNESS: If they stop working there is no guarantee that they will be re-x-rayed unless they make arrangements themselves to be at the place at the time and place.

25 DR. MUSTARD: Could it be possible then for a person to have worked with them in the fifties, to have left and moved to another part of the province and stopped working, and come down with chronic chest disease and be diagnosed in the local community without paying attention to the asbestos story, just having chronic chest disease?

30 THE WITNESS: Dr. Mustard, I feel that if you had said asbestosis I would say that the chances are good that he might



THE WITNESS: (cont'd.) be missed. As far as chronic chest disease is concerned...

5 DR. MUSTARD: What I meant is some kind of chronic problem, chest disease...you would get labelled with something other than asbestosis. He would come down with asbestosis...

THE WITNESS: Oh, he would get labelled with something else?

DR. MUSTARD: Yes.

10 THE WITNESS: In that case, yes, it's possible. I would think that it's possible.

DR. MUSTARD: Do you have any idea of how many people that might be an outcome for them? In another sense, they are not being picked up by the system?

15 THE WITNESS: I could only answer your question if I knew the turnover at Johns-Manville and if they were prone to move after they left the plant. I would suspect that...I wish I could say. If indeed they did, then I think the chances of them being undetected would be good...someone who is not up to date and who may not have been told of his exposure.

20 Sometimes the person doesn't tell his physician of his exposure, and the physician can't know unless the physician is unusually perceptive. Yes, I think it's a point you have.

MR. LASKIN: I don't have any more questions, Mr. Chairman, other than to thank Dr. Stewart for being so patient with me.

25 DR. DUPRE: Maybe just before we take a little break, I might just ask one question that takes us back to the rehabilitation program, but more especially asbestos fiber dust effect guideline.

I read that guideline that appears on page five, 30 seven, Dr. Stewart, and as a layman who knows absolutely nothing about the terms that are used, I nonetheless had an immediate surge of familiarity, because it looked to me like what I read in



5 DR. DUPRE: (cont'd.) regulations that tried to distinguish whether a transaction has given rise to income or to a capital gain. There is a lot of this in public administration literature, and I guess that the thing that then went through my mind is that quite evidently this kind of guideline could only, of course, be devised by an individual or a group who had very considerable familiarity with x-ray readings of people with different kinds of pulmonary problems. Is that a fair assessment?

10 THE WITNESS: I would say that - generally true. You can be pretty narrow in your specialty, you know, and still look good, but you are still narrow. I have a great familiarity with the dust diseases and the changes - perhaps less so with clinical diseases like sarcoid or...although sarcoid is a differential that you always have to consider in any of these...but yes, I think it's 15 a fair assumption to say that this is the result of some study and knowledge in this area.

20 DR. DUPRE: In the devising of those guidelines at this point, would experience in having read the x-rays of unsuccessful asbestosis claimants, who subsequently developed asbestosis, have been useful?

THE WITNESS: The...

DR. DUPRE: I'm asking it hypothetically, but I'm wondering, am I on the...I'm wondering if that was done.

25 THE WITNESS: All right. Can I give you this explanation? When we were asked to go into Johns-Manville we did not have a definition of pre-asbestosis. It wasn't in the books. It had never been recorded as it had been in the mines, in the silicosis, and we had to assume that there was in fact an incipient phase of asbestosis. It's arguable, but you have to assume that like silicosis there is a gradation of change between normal and abnormal, that somewhere in the middle you can't say is asbestosis, 30 but that in some people that you know has progressed to asbestosis.



5 THE WITNESS: (cont'd.) So you try to pick out that phase of the change that you know in others has led to the disease - not necessarily, but in many. The only way you can do that is to look at the group of people that are involved, and don't forget that Johns-Manville employees were exposed to quartz also, so your picture was a little different than it might be.

10 That's what Dr. Ritchie said yesterday, that there is...he has found some silicosis with some people who show asbestosis. This must surely be from Johns-Manville and nowhere else.

15 So the guidelines, of necessity in this case, had to be developed from the Johns-Manville films, and were not predominantly, and cannot be interpreted as such, as representing asbestos changes that might occur in other industries such as mining or textile work. They were devised from this particular point of view, and in fact they were devised from serial films which were examined, from all Johns-Manville employees.

20 I may add, that in trying to set down this I discussed this with Dr. Vingilis and with members of the advisory committee, that these were not developed...these were an amalgam of the advice I received and my own thoughts, and I showed these guidelines to Dr. Vingilis, for instance, and we discussed them, and we discussed them with Dr. Roos, and we felt they were reasonable.

25 So...but I can say that it's arguable...that you can argue that what I am describing is in fact asbestosis. Once again, it will depend on the industry in which it's in, and that in fact I might argue that the changes that I have described may not necessarily go on to asbestosis, but in Johns-Manville we know have, in some people. Only time will tell as to whether these are accurate, but we feel they are accurate because they are a selection of the findings in people who were not labelled asbestotics by our advisory committee and by the chest disease service themselves.



5 THE WITNESS: (cont'd.) They are in detail...more detail, perhaps...than one would like, but if we are asked to describe something and to justify it, we must put something down so that the Board can at least get an idea of what we are doing.

DR. DUPRE: Thank you very much, Dr. Stewart.

Shall we take our break now, and I presume I will be given a batting order on our return?

10 MR. LASKIN: You shall.

DR. DUPRE: Thank you, counsel.

THE INQUIRY RECESSED

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THE INQUIRY RESUMED

15 DR. DUPRE: Have I got a batting order? Are you going to lead off?

MR. McCOMBIE: Yes, I'm the leadoff hitter.

DR. DUPRE: If you please.

CROSS-EXAMINATION BY MR. McCOMBIE

20 Q. Dr. Ritchie...Dr. Stewart, I'm sorry...at the beginning of today's session you answered some questions about your background, that Mr. Laskin asked, and I would just like to clarify a couple of things on that.

25 First of all, you said you were working in Elliott Lake and you became particularly interested in compensation work. This is just through your...you had a general practice in Elliott Lake?

30 A. I said I became particularly interested in chest work. I did compensation work up there during my practice, but I became interested in chest disease through my association with the physician in charge of the miner's chest station, which was at that time run by the compensation board.



5 Q. I'm just trying to clarify how you were involved at that point in compensation work. Would this be patients of yours that had compensation claims that you were required to...

10 A. Yes. In a mining town you have quite a few of those.

15 Q. The other thing that I wasn't exactly clear on in your background, do you have a certificate as a specialist in chest disease?

20 A. No, I do not. No.

25 Q. Another, I guess, general question that has seemed to have been part of your answer in a lot of questions, and I'm wondering if there is any difference at all between your role at the Workmen's Compensation Board and the role of Dr. Dyer.

30 A. Would you see both yourselves having an equal role in chest disease, or is there one area that you would specialize in that he wouldn't...

35 Q. Well, I would...my position I hold is senior to Dr. Dyer's in the sense that I am considered a consultant and he is considered a specialist. We, however, work together.....although I do more of the appeal cases than Dr. Dyer. I suppose I would have the last word, if it came down to it.

40 A. But in the general day-to-day operation or flow of claims, there wouldn't be any particular claims that would be directed your way rather than Dr. Dyer's way, or vice versa?

45 Q. Dr. Dyer would do a lot of screening of claims that would otherwise, might come to me. I tend to attract more of the appeal cases. We, together, work on or submit opinions on cancer cases.

50 Q. Just to get to the actual setup, and you went through it to some extent this morning, where a claim would come in and it would come, as I understand it, initially to the ID and D section, who would then refer it to either yourself or Dr. Dyer?



A. Mmm-hmm.

5 Q. I guess what I'm curious about is, as I understand it, all claims are, before they go to the ACOCD, they go through either yourself or Dr. Dyer, is that correct?

A. That's true.

10 Q. Even when there is a very clear diagnosis from whatever source, it would still be funnelled through one of the two of you?

A. Yes.

15 Q. I'm just wondering, and I don't know whether you can answer this, but why would that be if, for example, a very clear diagnosis came in? Could not some fairly rudimentary medical education be involved with the claims adjudicators that they could refer directly to the ACOCD? I'm just wondering why this extra step is there.

20 A. I see. Well, at our desks we arrange the appointments with the advisory committee, the medicals arrange it, and not the claims department. The appointments are made from our desk.

25 Q. I understand that, but I am wondering if there is a particular reason for that other than the , I guess, more controversial claims? I mean, it would seem to me that it would speed up a routine claim, if you like, if that extra step were...

30 A. I don't know if there is much time lost in an extra step, and we are asked to ...well, I don't really think that much time is lost and it's desirable that we see the claim first, before it goes to the committee.

Q. So in any claim that would be submitted, at the initial stages the claims adjudicator would really have very little input? I mean, they would refer it directly to you, in particular as I indicated, a claim that would seem fairly straight forward on the surface, it would still be referred to you?



A. Yes.

Q. Is there, in your experience is there any kind  
5 of education or training that is given by yourself or other people  
from medical services, to claim adjudicators, paramedical training,  
recognition of words, things of that nature?

A. We have occasional meetings with the ID and D  
section, as a whole, and we, Dr. Dyer and myself, have in the past  
presented example cases and discussed issues and problems that we  
10 know have arisen, that are common to us both. So we do have, in a  
sense, a continuing education program when we feel it's necessary,  
and at the request of a supervisor.

Q. I'm wondering if that kind of an education program  
would work in the other way, whether...and perhaps this goes back to  
15 your first joining the Board, whether yourself and Dr. Dyer are  
ever involved in discussions on, I guess, the more legal aspects  
of compensation, in that kind of a training approach?

A. Not really. The legal aspects of our work  
I think are simplified for us in that we derive a broad right to  
do what we do from the Act, without too many constraints to it.  
20 That is, we are not given definitions or limits, as it were, that  
have been suggested, say, in some of the...take Professor Eissen's  
report, where he goes into detail and breaks down legal versus  
medical. They don't seem to exist in our system.

But the system seems to work, in my view, without  
25 these constraints on the medical branch.

Q. So I gather you are referring to Professor  
Eissen's three page chart at...?

A. Right. Yes.

Q. You don't think that that is applicable to the  
Ontario board?

A. I don't see how it can work in our system, our  
30 particular system.



5 Q. So in other words, for that particular outlook to work it would have to change a lot more than just changing peoples' duties, you would have to change the whole structure?

A. Yes, I would interpret that.

10 Q. Just one other point on the primary adjudication. I believe you mentioned this morning that when a claim comes to you, you do have access to a fairly large number of occupational chest disease service reports, is that correct?

A. Yes, that's true.

15 Q. Would the claims adjudicator have access to those reports as well, or would they ever have occasion to use those? I mean, would that be something that could be done at the initial stages to cross-index or cross-reference a particular claim with a report from the ministry?

20 A. He doesn't...no, they do not have copies as we do. They are stored in our offices, and copies are not sent to the claims department.

25 Q. Now, earlier today Mr. Laskin was asking you some questions about appeals, and you indicated that you are more likely to be involved in that stage of things than Dr. Dyer, so you indicated that, if I'm correct in my memory, that the appeal board has accepted a claim that you had recommended against. I believe that was your testimony?

A. Yes. I can recall a claim in which my opinion was not sustained by the appeal board. He elected to go elsewhere.

30 Q. This was on the basis of contradictory evidence, presumably, from another source, or different evidence anyway?

A. I'm not too sure of the basis for the way the board went. I can only say that my advice was disregarded.

Q. But it's only, to the best of your recollection, at the appeal board level that this has happened? It hasn't happened at an earlier stage, at the appeals adjudication or...?



5 A. I can say that...I can't say this specifically about asbestos. I'm aware of an occasion in which an appeals adjudicator has decided to ignore my advice.

Q. On something other than asbestos?

A. Yes, I think it is. I can't remember that it was an asbestos claim. It was something else. In fact, it could be more than once, but I...

10 Q. I guess the bottom line being that whether it's asbestos or not, it is a fairly rare occasion when your recommendation is overruled at the appeal level?

15 A. Let's say that it's relatively rare at the appeals adjudicator level, but I'm not certain that it is necessarily rare at the appeals board level, because I'm not necessarily told how the claim goes. In fact, in some claims I'm interested to know what happened, but I have never found out. So I can't say.

Q. Okay. And on the question of appeals, Mr. Laskin also asked you whether you had ever given evidence at an appeal hearing and you indicated that you hadn't.

20 I guess one of the questions that arose in my mind, and we did hear from Mr. McDonald about this the other day, that this was not done...I just wonder if you personally would object to appearing at a hearing that a claimant had, to explain your position?

25 A. Well, I'll answer it this way: At that time, the time the appeal is heard, I have tried to set down in as much detail as possible the reasons for my opinion, and I mean detail...I try to.

I would like the appeal to consider that opinion, along with the evidence that might be given, and let them decide on their own.

30 Now, as far as being cross-examined is concerned, I would be prepared to submit to that if that was the system, if



A. (cont'd.) that was the arrangement.

The answer, I guess, to your question is yes. I would.

5 Q. So you don't have any particular personal aversion to appearing at a hearing?

A. I don't think so. I don't think so. No.

10 Q. Okay, just to turn for a moment now to the advisory committee, when the file comes to you and is referred by you to the advisory committee, and you have outlined, I think, in a fairly detailed way what is required of the advisory committee and generally what they will respond to you, but I'm wondering...we have had some testimony on the advisory committee and who is on it and how it is set up, and frankly, I'm still somewhat confused by the whole thing and exactly what their relationship is.

15 I believe you said earlier today that in your view the advisory committee is advisory to the Workmen's Compensation Board rather than to Dr. Stewart and Dr. Dyer?

A. Oh, yes. Absolutely.

Q. Now, as such, do you see the advisory committee as an independent consultant to the Board?

20 A. Well, I've never known of any individual in the Board, including myself, to try to influence them in any way, so I have presumed that they send us a perfectly independent opinion. I presume that they are physicians who have pride in their work and who would resent any interference on my part or anybody from the Board.

25 Q. So there is no direction on your part, or as far as you know, anybody from the board, as to how they are to conduct their business?

A. We have never told them how to conduct their business. No. All we want is the service that we ask for.

30 Q. Can I ask you whether, to the best of your knowledge, there has been any reluctance on the part of the Board



Q. (cont'd.) to have the advisory committee make a report to a third party?

5 A. I am aware of one occasion in which this came up. The issue and the case itself was dealt with by my superior, the medical director.

Q. That would be Dr. Dowd?

10 A. Yes. So I am not really privy to it, and I have not had any part in it.

10 Q. But if someone from the committee phoned you up and said that a report was requested by the patient or a representative of the patient, would your response be to refer that to Dr. Dowd, or would you have a response yourself on that, or would you have any objections yourself on that?

15 A. I would know that the request seemed to run counter to one of the provisions in our Act, and I think I would refer that to my superior.

DR. DUPRE: Do you recall what provision of the Act you are thinking of, Dr. Stewart?

20 THE WITNESS: Is it one zero one?

UNIDENTIFIED SPEAKER: Section one zero two, I believe.

DR. DUPRE: Section one zero two. Correct.

25 MR. McCOMBIE: Q. Okay, I would like now to turn to the question of rating, and I believe from your testimony this morning you made it clear that if entitlement were established, the ACOCD would also give a rating to the individual, and then the report would come back to you indicating that they felt that entitlement were established, and what the percentage rating was.

Now, I believe your testimony was that most of the time that rating was acceptable to you and recommended by you to the claims adjudication branch?

30 THE WITNESS : A. Let me clarify that. I might not make any recommendation, I would simply send the report on to the



5 A. (cont'd.) supervisor of the ID and D, and let him deal with it. I wouldn't make a positive recommendation, because the fact that I sent it on without any comment is positive recognition.

10 Q. Okay. I believe you also indicated that occasionally you might have questions of either the entitlement aspect or the percentage, in which case I believe you said that you would write back to the ACOCD, or get in touch with them, and discuss it with them?

15 A. Yes. Yes, on occasion I will. It's not very often that I do this, but occasionally there are points that need clarification, that I see possibly the recommendation and the conclusions are maybe not quite compatible with the body of the report through some error, some possible error of statement, of grammar, error of explanation that wasn't explained well - something that I was a little unsure about and that I would like clarified. On occasion, I have asked a clarification of the actual award.

20 Q. The percentage award?

25 A. Yes, in a sense that if I am aware of the fact that possibly it's a first award, if it's a first award, and that it was fairly high to begin with. On occasion in the past, occasionally in the past, I have clarified this report also...if I knew at the time that this was a first award and that it was fairly high.

This happens very rarely, but in the past it has happened and it has been one of the reasons why I have asked.

30 Q. Accepting that it does happen fairly rarely, I'm wondering if in those rare circumstances whether they are always...a consensus is arrived at, or whether there has ever been an occasion where there is an irreconcilable difference between



Q. (cont'd.) your view and that of the ACOCD, or whether it is just a question of grammatical or minor differences.

A. I must say I don't recall any occasion in which there has been an absolute divergence of views where we could not accept their report. We have left...I can't remember...a recommendation for an award is their recommendation and unless we have very good evidence, some reason to recommend against it because of a legal reason or some technical reason possibly, it's not done, I guess.

Q. And then this recommendation, assuming the majority of cases where you would be in agreement with this recommendation, would then go back to the claims, and then they would deal with it?

A. Yes. Right.

Q. Do you have any idea as to...and I realize that this isn't your area...but I'm wondering if you have any idea of whether the claims would in any way alter that award to take into account anything, any other factors or whether they would automatically implement the award, the percentage amount that has come through you from the ACOCD?

A. Unless they discovered something wrong with the claim and with the rights of the claimant in respect to exposure and his right to the award, they would accept it as such and may even add on to it. They might consider a supplement or some other award like that.

Once again, I'm not expert in that particular area and...

Q. But assuming that everything was in order, and leaving aside for a moment the question of supplements, in your experience it would be...taking the hypothetical figure of, say, twenty percent that was recommended by the ACOCD, it would go through you and then would appear from the claims adjudication



Q. (cont'd.) branch as a twenty percent permanent disability award with no variation?

A. Yes. With no variation, as far as I know.

5 Q. The reason I'm curious about this, and it gets back to some extent to the ongoing dispute or discussion, I guess, around impairment versus disability, I'm reading now from the Board's guidelines on the rating of permanent disability, from the Board's Policy Manual, directive one. If I could just 10 quote the first two sentences here, and I gather this would primarily apply to the traumatic injuries? I'm assuming that there wouldn't be any great difference in ID and D claims. You can correct me if I'm wrong.

A. Well, maybe I should...

15 Q. Anyway, it says:

"Responsibility", quote, "The medical branch, medical services division, is responsible for the estimation of clinical impairment in injured employees.

20 The claims adjudication branch, claims services division, is responsible for estimating the impairment of earnings capacity and estimating the level of post-accident permanent disability".

End quote.

25 This seems to indicate to me that the claims branch does have some role in arriving at the final figure, the final percentage, that seems to not be there in the process as you describe it.

Am I wrong in that assumption?

30 A. I think it depends how you interpret that section.

Could I see this?

MR. LASKIN: Sure, Dr. Stewart.



5 THE WITNESS: This refers to the pension medical staff. I would think it would refer specifically to our pension medical officers and the pension medical section within the medical branch, if I'm not mistaken.

MR. MCCOMBIE: Q. So when this says the medical branch, medical services division, is responsible, etc., that would refer to the medical staff of the pensions branch?

10 THE WITNESS: A. I would think specifically, because I have not been asked to comment on this before.

Q. Well, maybe if you could turn the page and on page sixty-two, under permanent disability rating guidelines, under two point one, and I'll read this out...I apologize that I haven't made copies of this...it says, quote:

15 "It is the pension adjudicator's responsibility to authorize the assessment of all cases for permanent disability evaluation, except those cases emanating from appeals."

Again, this seems to place more of a responsibility on the...in this case, the pensions adjudicator, and I understand that when 20 we are dealing with industrial disease claims that is all rolled up into one responsibility with the claims adjudicator, and it is not divided as it is in traumatic injuries.

25 Reading this over, it seems to me that there is more of a role required of the pensions adjudicator, or indeed the claims adjudicator, than I understand from your testimony.

A. Well, what does he mean...I'm not too sure what you mean by assessment of all cases for permanent disability.

30 The act of assessing disability in pulmonary disease is certainly not the role of a pensions adjudicator, and if there is a paradox here, it simply may refer to the fact that trauma and pulmonary disease have different values and have to be treated a little differently.



5 Q. So would you say that in adjudicating, using the broad sense of the word, claims from the traumatic side it would be different than adjudicating those from the disease side?

10 A. Only in the approach. I think in the end, in the final analysis, the results are the same - that the pensions medical officer recommends an award, a percentage award, in the same way as the advisory committee recommends the percentage award. I'm not aware that the pensions adjudicator changes that award recommended by the pensions medical officer.

15 Q. I just might add that I think you are right. That doesn't seem to us to be the case that it is changed. It's just that it seems that in practice it seems different than what we are told in theory.

20 A. I would like to come back to this in a minute, but the other thing that I am curious about is the whole question of the psychological impact of a particular worker that has received, that has an asbestos-related disease, and whether or not the Board - either yourself or through the advisory committee - ever takes psychological considerations into account in arriving at a pension or in benefits of any kind?

25 Q. I'm not aware that the committee has done so. If they chose to, and incorporated into the award, as it were, or took it into consideration in coming to a conclusion regarding the amount of the percentage, and they didn't indicate that they had done so, well, it would be up to them. We would have no way of knowing that they had taken this into consideration.

Q. But as far as you know there is no guidelines for that, for example?

30 A. No. We have not talked to them about this. We have not discussed it with them. If they chose to include it, we have not known about it.

Q. Has it ever been considered....you are aware



Q. (cont'd.) in traumatic injuries there is occasionally a different award, another permanent disability award for psychological...  
5

A. I'm aware in traumatic injury that it is an issue of separate consideration that is dealt with separately, and may be added on to the award, the trauma award. As far as I know, this may be the case.

Q. Do you know if it has ever been the case with  
10 asbestos claim?

A. Not that I'm aware.

Q. To move to another subject for a minute...I appreciate your comments on this...it's something we discussed to some extent yesterday with Dr. Ritchie, and has appeared in some of the research papers and responses, and that's the question of  
15 autopsies.

Dr. Ritchie testified yesterday that in his view an autopsy was a very good tool to use, and certainly Professor Barth has used that it is not used very often in Ontario.

I asked him the question yesterday, which I would  
20 now ask you, whether or not the Board has ever considered any program to encourage autopsies among asbestos claimants?

A. First of all, we have on occasion asked the attending physician to obtain an autopsy in an individual who we... was terminally ill, and who we had seen and was a pensioner of ours, and when the diagnosis was obscure and we weren't certain  
25 of it.

We occasionally have written the physician or phoned him - more often phoning him. I don't know if we have ever written him, I don't think I have ever written him. I have phoned the odd doctor and asked him, but it doesn't happen very often, and often we don't get a chance because we are not aware  
30 of the death until it's too late.



5 Q. In a perfect world, if you like, although in a perfect world we wouldn't have asbestos victims, but in a perfect world would it be advantageous for every asbestos claimant to have...or every asbestos claim to have an autopsy available?

A. I would say yes, with one condition, with one reservation, that every claim for asbestosis...

Q. Every recognized claim, perhaps?

10 A. Right. Yes. I would think it highly desirable.

15 Q. Is there not...and perhaps I'm asking something that is under consideration or hopefully will be under consideration... but do you know if there is anything that the Board is looking at doing as far as education or advertising, I guess, to family physicians, or Dr. Ritchie mentioned unions yesterday, is there any kind of program the Board has ever looked at or is willing to look at to try and encourage autopsy reports?

A. I would say that we are certainly willing to look at it. We haven't formally gone into it.

20 The problem is that there has seemed to be a steady decrease in the actual numbers of autopsies that are being done routinely, but perhaps even more important - we are not informed and we haven't the time to request the physician to obtain the autopsy. It's too late after a week, or two weeks, three weeks, when we are finally notified.

25 Q. I understand it would be difficult after someone has died, but I'm wondering if there is some sort of pre...similar to the letter that Dr. McCracken sent out in 1976, I'm wondering if there is any kind of a role that the Board might fill along those lines.

30 A. I am in favor of it, frankly. I think we could do something in that direction. Perhaps we could do more. Perhaps we should do more.



5 Q. Okay. I have now had a copy made of another piece of correspondence, and if you will indulge me I would like to return for the moment to the question of assessments, and perhaps... this is a letter to Injured Workers Consultants from Dr. McCracken, and it relates to back injuries, and if I'm going off...if...under the assumption that there is no difference in the procedure between traumatic injuries and disease, and please let me know, but I would note in particular the last paragraph of Dr. McCracken's

10 letter, which states:

15 "Lastly, I should point out to you that the physician's staff does not evaluate disability, but only impairment. A person who has impairment may have no disability and no handicap. However, they may have disability, but no handicap. And finally, they may have both disability and handicap.

20 This portion, in the determination of awards, is the responsibility of the pension claims adjudication staff, in view of the fact that it represents a socioeconomic problem."

25 Again, I'm somewhat lost because this to me seems to indicate that there is a more active role that, in this case, the pensions adjudicator would be taking in the final awarding of the percentage, than we have heard.

30 A. Well, I would think that he is saying, in effect, that the pensions adjudicator can do what he wants, and he may, if he chooses to, double the award or triple it, if he wishes to. That is up to them.

As far as the medicals are concerned, they are simply suggesting a degree of impairment that you could call disability if you wish, because impairment is really functional disability, but it's semantics again, and under our system, I believe, we are essentially measuring loss of function...loss of



5 A. (cont'd.) function. We are awarding for loss of function, not for the degree of function remaining.

I think that's essentially true in trauma and essentially true in pulmonary disease.

We are merely recommending to our lay colleagues at the Board, as to this. They are perfectly at right to do what they want with that.

10 Q. Okay. So if I could just briefly summarize what you've said, that you recommend a percentage that you feel represents the impairment, and either the pensions adjudicator or the claims adjudicator can then do whatever they want - they can increase, decrease or just pass on what the medical people have said?

15 A. It's their right, as far as I know.

Q. But as far as your experience go, that rarely, if ever, happens - that they change the percentage award?

20 A. This is my experience. They may add on to it a stacking benefit, but the actual numerical award I believe stands generally unchanged.

Q. Just one other brief area I would like to touch on, and that is...

25 MR. LASKIN: Could you just identify this letter, for the record, so that we all know we are talking about the letter from Dr. McCracken to Miss Marian Endicott, Community Legal Worker with Injured Workers Consultants, dated March 4, 1982.

DR. DUPRE: I guess you want to give it a number, counsel?

MR. LASKIN: I'm going to ask Miss Kahn to give it a number.

30 MISS KAHN: That will be exhibit four of phase four.

MR. LASKIN: All right. Exhibit number four of phase four.



EXHIBIT # 4, OF PHASE 4: The abovementioned document was then produced and marked.

5

MR. LASKIN: Sorry, Mr. McCombie.

10 MR. McCOMBIE: Q. I would just like to briefly ask you, Dr. Stewart, and again I don't know if this is an area that you have considered or not, but this is relating to some of the changes suggested in the White Paper on Workers Compensation, and in particular I would be interested to hear your views on what may or may not happen if the medical review panel as envisaged by both Weiler and the White Paper were to come into being, and how that would affect the flow that has been established between yourself and the ACOCD.

15 Do you see this being a problem at all?

20 THE WITNESS: A. Well, it's hard for me to be dispassionate when I'm asked to possibly discard something that I feel has worked so well for so many years, and predict whether the alternative is going to be as good.

25 My first impression would be that I wouldn't like to see the change, but that's not to say that some other alternative is not viable. It's just that based on our perception of medical panels, at the Board, and our knowledge of those in other jurisdictions, that might not be a good alternative to the AC, so I would have some reluctance.

30 Q. I guess the reason I asked that is that my perception is that the ACOCD is seen as the gathering together of people with a great deal of experience in a particular field, and I suppose depending on how you look at it, a medical review panel dealing with asbestos claims might be seen as not having the same degree of experience, or not having the same degree of expertise. Is that a fair summation of what you are thinking?

A. It could happen. Put it that way, it could happen. It could work out that way.



A. (cont'd.) There is no guarantee that it wouldn't, but...

5 Q. The other question I would have for you on the proposed changes, I guess I should start with the current system and ask you whether or not your opinion is sought in defining what an individual who has already been rated at...take a figure out of the air - twenty percent...what that person can or cannot do in the way of returning to their previous employment, let us say. Would you be involved in indicating what this person can do? You know, this X amount of work?

10 A. Yes, I might be asked that question by the claims department if it was not clear, and if it was an issue that was brought up by the person - who might well claim that the award wasn't big enough because he couldn't do his work. I may well be asked to comment on that, by the claims department.

15 Q. So that this is, again, I gather you are saying it's not a major role, but it's certainly something that comes up from time to time - in particular, I would assume, with people that do have permanent disability awards that, for whatever reason, have not returned to their previous job?

20 A. Yes.

Q. Your advice would be sought as to what they could or couldn't do?

A. It might be. It's not a frequent request.

25 MR. McCOMBIE: Okay. I think that's all the questions I have, thank you.

DR. DUPRE: Mr. Cauchi.

CROSS-EXAMINATION BY MR. CAUCHI

30 Q. In the Barth Report, I noticed this morning you mentioned the pulmonary function test. When were these tests started at the Johns-Manville plant?



5 A. As far as I know, screening of asbestos workers in Ontario started some time in 1952. I would suggest at about that time.

Q. At the Johns-Manville plant?

A. I am aware that routine screening ...

Q. I'm talking about the lung function tests.

10 A. Oh, I'm sorry. I'm sorry. I'm talking of the x-rays.

I don't know.

Q. You don't know?

A. No.

15 Q. Where do the reports come to the claim department for an individual claim? Do they always come from the family physician, or from the union representing the worker?

A. They may come from anyone. I don't...I can't tell you the...

20 Q. Okay. They come from...they may come from anyone, you say?

A. Yes.

25 Q. Do you ever recall at any time a worker's physician putting in a claim for compensation?

A. Yes. A worker's physician has often...

Q. A worker's physician?

A. Yes, yes.

25 Q. It is a rare occasion, isn't it?

A. No, I don't know as it's rare. It's not uncommon that a worker's physician will request that a claim be entertained for his patient.

Q. But it is a rare occasion at the Johns-Manville plant?

30 A. Well, I...since I do not deal with all the initial claims, I couldn't say for sure on that. I really don't know.



Q. You mentioned about the details of exposure history. How much do you rely on the management detailed exposure history reports?

A. At Johns-Manville?

Q. Yes.

A. Fairly heavily.

Q. Fairly heavily?

A. Yes.

Q. Does the individual ever know about the detailed management report?

A. Does he ever know what is in that report?

Q. Yes.

A. I'm not aware that a copy of that report is sent to...

Q. The worker?

A. ...the worker. I'm not aware that that is so. It might be, but...

Q. So the employer can say whatever he wants to say in the reports, about the employment exposure of the worker, without the knowledge of the worker himself?

A. Yes, that seems to be possible.

Q. The x-ray...

DR. DUPRE: Excuse me, Mr. Cauchi, I just wanted to ask a little point of clarification on that.

MR. CAUCHI: Sure.

DR. DUPRE: It would appear to me that the form seven S, which Professor Barth reproduces on page two, thirty-four, would be a form on which such information would be given.

Now, that form would be part of the claim file, would it not?

THE WITNESS: Yes, yes.

DR. DUPRE: Now, that being the case, is it not so



5 DR. DUPRE: (cont'd.) that a worker who wound up appealing would wind up, if he got the claim file or if his representative got the claim file, seeing the form seven S?

THE WITNESS: Yes, he would at some stage be able to see it.

DR. DUPRE: Okay. But he would have to appeal to be able to see it?

10 THE WITNESS: Mmm-hmm.

DR. DUPRE: Yes. I guess that would be my understanding of the way your whole system works.

15 THE WITNESS: So it is, except let me just say that is this claim went to the advisory committee, the advisory committee would question him on their own to elicit their own...they would of course look at this, but...

DR. DUPRE: At the time they are taking the patient history?

THE WITNESS: Yes.

DR. DUPRE: Go ahead.

20 MR. CAUCHI: Q. In my experience, it is rarely the family physician who ever signs these forms. It's always either the company physician...

25 THE WITNESS: A. It could be true. You might be right, and you probably are. It's just that I have no knowledge of the frequency of this, and under our system anybody...or I'm sorry, not anybody...any physician can.

Q. You also mentioned in a question this morning from the Commission here, about the rating, the classification rating from one to six. It says that your rules are published for the pre-silicosis, not for asbestosis, and it was also used for asbestosis at the Johns-Manville plant.

30 Is it still being used?

A. My understanding of it is that if a person's



5 A. (cont'd.) x-ray has changed to where one can diagnose pre-asbestosis, okay, that it's not labelled as a code four, it is a descriptive label.

But if it was labelled a code four, I would understand it. To me it would be understandable.

Q. But to the man itself it's not understandable.

A. Ah, it is not understandable.

10 Therefore, that's why generally, in the letter that is sent out, or in the report, the changes are described.

Q. Sent out to who?

A. To the family doctor, the company doctor. These reports now are sent to the family doctor or the family doctor.

15 Q. So why would the system still be used as of last May, at the Johns-Manville plant? The rating system?

A. What rating system are you talking about?

Q. From one to six.

A. It was still being used?

Q. Yes. As far as last May.

A. My reports...our reports show description.

20 As long as there is a description, it doesn't matter what they label it. Okay? It doesn't matter. The label is of no use. It's the description of the change.

Q. For someone who knows what the description is, it's all right. But for someone like me, to look at one to six, doesn't know nothing about it, a worker, it means a lot.

25 A. But we are not asking you to interpret one to six. We are asking you to interpret the description of the x-ray.

Q. Yeah, but for someone that's looking at the card and see number four or number three, knows what it's all about, like you people, it's easy. For someone having the x-ray taken and look at his card and see number four, like when I go for my x-ray I see number four or number three, I don't know what is that all



Q. (cont'd.) about. I think I might be fourth in line when it says number four.

5 A. Doesn't your doctor get a report?

Q. My doctor?

A. Yes.

Q. My doctor will usually, you know yourself, normally the reports were never sent to the family physician until 1975. They were always sent to the company physician.

10 A. Yes.

Q. You recall that. And we managed to change that at the time, but now why is it changed again that unless the worker that's being assessed by the chest disease clinic at Grosvenor, if the worker don't advise the physician that is giving the medical to send the report to his physician, his physician never receives 15 the report?

A. You are talking of the advisory committee?

Q. No. I'm talking about the...

A. You are talking about the chest disease service.

Q. ..chest disease clinic. I don't know what you 20 call that clinic.

A. All right. Okay.

Q. Is there a change in the system, guidelines, or what?

A. I must be frank here. This is not my area. I am not a member of the chest disease service.

25 Q. Oh, okay. It's not my area. You got me there, but do you always get the reports from the chest advisory, chest disease clinic?

A. Yes. We receive copies of x-ray reports that are derived from the surveillance program.

30 Q. For every asbestos worker?

A. For every asbestos worker.



DR. DUPRE: Not just for every asbestos claimant,  
but every asbestos...

5 THE WITNESS: Oh, the workers - every asbestos  
worker.

MR. CAUCHI: Q. Yeah, not only the claimants?

THE WITNESS: A. Every asbestos worker.

Q. So if a man is being rechecked two years from  
now, you would know the difference between his x-rays 1980, and  
10 his x-ray in 1982, whether it has progressed or not?

A. Only if it is mentioned on the report. We do  
not keep a separate file for each man, so we would not know.

Q. You don't...

15 A. We keep lists of x-rays. We keep thousands of  
reports, and we file them by company or by the industry. They  
are not filed in a separate file for each man, so unless the report  
in 1982 states that there have been changes over the last two years,  
we will not know if there would be changes. However, it is my  
understanding that this is always set down - that if there are  
changes, it's stated.

20 So I wouldn't have to go and see the report two  
years before.

Q. So what you are telling me, if an asbestos  
worker is examined in 1980, at the clinic, 50 Grosvenor...we call  
that the advisory...

25 A. Oh, no. That's the advisory committee, yes.  
Sorry.

Q. The advisory committee, yes. And he has found  
that no chest disease, or no disease is...let me explain it to you  
what it says in here:

30 "There is no evidence of an industrial chest  
condition".

In 1980, it says on his report by Grosvenor, that no...that report



Q. (cont'd.) goes to you, too, correct?

A. Yes.

5 Q. Now, say some of them that I know, haven't been called back for the last five years, so say five years ago, 1977, he was checked and he was given a clean bill of health that there is no disease. But five years later, he is called and they find out that the man is...there is some disease.

10 DR. DUPRE: The report goes to you, and you assess him at thirty percent, ten percent or whatever. He is assessed a percentage. Is that retroactive to five years ago?

15 A. It may well be. We have not infrequently recommended a retroactive award if, when we see the man for the first time, his disability is more than minor, and if we receive a report that says this man is thirty percent disabled, we will generally work out some retroactive system.

DR. DUPRE: Let me see if I understand this.

You will work out a retroactive system where an individual, when his claim has first been looked at...

THE WITNESS: After it has been processed.

20 DR. DUPRE: Yes. Has had his claim processed at a relatively high percentage disability rating...

THE WITNESS: Yes.

DR. DUPRE: ...like thirty or higher?

THE WITNESS: Absolutely.

DR. DUPRE: Okay.

25 But on the other hand, let us take an individual who, say, first puts in a claim in 1980.

THE WITNESS: Yes.

30 DR. DUPRE: The last x-ray that you have on him out of the surveillance people is 1978. The 1980 x-ray shows that there has been quite substantial deterioration. But in that case, the disability award would be...would not be retroactive to 1978,



DR. DUPRE: (cont'd.) presumably, when the x-ray didn't show anything?

5 THE WITNESS: In other words, you are saying that in 1978 it was okay, or relatively normal. In 1980, it wasn't.

DR. DUPRE: Yes.

10 THE WITNESS: If I was asked to consider this by the claims department, I would well recommend that we put it back to the year before - split the difference and start the...I have made recommendations, not frequently, to put the award back for five, six, seven years, on some occasions where we...

15 MR. CAUCHI: Q. Do you recall if it has been done like that? Do you recall any specific cases that it has ever been done?

20 THE WITNESS: A. I can recall a case that was not connected with Johns-Manville. It was with another firm in Ontario where we recommended a seven or eight year retroactive award, and which the claims department accepted.

25 No question that if we find that the disease started well before the time that he was examined by us, and that everything else being equal, then we will start the award then.

Q. I'm confused now. The claim that you are talking about where it was a death...

A. I'm not talking of any particular claim. Not connected with Johns-Manville, the claim.

25 Q. I'm concerned with a ten percent, say, disabled person in 1978, and he has not been examined until 1985. So in 1985, he is going to be assessed at fifty percent.

A. Yes.

Q. So what happened during those seven years? Is he going to back to fifty percent, back to 1975 or what?

30 A. I would probably average it out over those five years.



Q. You don't recall it ever being done for any Johns-Manville worker?

5 A. It could well have been done. I just don't recall it.

Q. I don't, I tell you that.

Now, I guess like you mentioned there, that they used quartz at the Johns-Manville plant, to produce their type of products in there, and are you aware that the J-M workers were not checked for asbestosis until 1963?

A. I'm not aware of that, Mr. Cauchi, no.

Q. According to the Ministry of Labour statistics, they were checked for silicosis.

A. I know they started silicosis in 1951, 1952, but...

15 Q. As a matter of fact, the first claim for compensation at the Johns-Manville plant was for silicosis.

Now, bear in mind that we have been talking about asbestos claims, and we heard from Mr. McDonald the other day that they called that the mineral dust effects now, correct? They don't call it asbestos dust or silica dust effect?

20 A. Well, no. It's...mineral dust effect is a synonymous term. It's just a more general term.

Q. Sure. Is it because that at the Johns-Manville plant we used asbestos cement, silica and many other foreign materials? Or just because they are taking overall picture of 25 all the chest disease conditions - whether you worked in the mines, or silica, or rock salt, or whatever.

A. No specific reference to Johns-Manville reflected in the mineral dust effect term. Is that what you are saying?

30 Q. Yes, yes.

A. No.



Q. And the asbestos dust effects terminology was created just for the Johns-Manville people, correct?

5 A. No, not correct.

Q. Not correct?

A. No, no.

Q. Why it was the asbestos dust effect? For whom?

A. Asbestos fiber dust effect you are talking about?

10 Q. That's right.

A. For whom?

Q. The terminology was created by who, and for which part of the country or which group it's meant?

A. Well, we created it in the sense that we were asked to distinguish the people who did not have asbestos, but who weren't quite normal. So as a group we sought to classify them into the asbestos fiber dust effect, as we did with people in the mines who were exposed to quartz.

Silica particle dust effect, we would..if you wish to be...we have the asbestos fiber dust effect.

20 Q. That didn't take place until 1976, correct?

A. That's true, although...yes, that's true.

Q. Now, in dealing with presilicosis or preasbestosis, or until you go to asbestosis or lung cancer or what have you, are you aware or have you any statistics of how long it takes for a worker that works, say, ten or twenty years in the asbestos industry, that is suffering from asbestos dust effects, for that person to develop asbestosis, lung cancer, mesothelioma or what have you?

A. No. I can give you a rough estimate in our system and in our experience, in respect to people who are code four in the mining industry, how long they took, on the average, to proceed to code five - probably anywhere from five to eight years, and we have figures on that. But we don't have figures developed



5 A. (cont'd.) for the asbestos industry, and we only have figures for the mining industry because we have been keeping statistics...we have statistics going back to 1925.

Q. That leads me to say, ask the next question.

How does one come to the conclusion of whether a worker is suffering from asbestos dust effects or early asbestosis? What is the difference?

10 A. I agree. It is strictly a judgement call. It is an x-ray evaluation primarily, and the person with asbestos fiber dust effect would not be expected to have any abnormality of ventilation, any abnormality of their pulmonary function. It is primarily an x-ray entity.

15 So you asked me...all I can say is that we tried to define it and we try and work from that baseline.

15 Q. Are you aware of anywhere else in the world that uses the terminology 'asbestos dust effects'?

A. No, we are not.

Q. Just Ontario?

20 A. Yes. I do know, however, that there are people who feel that the effects of asbestos dust inhalation should be assessed sooner, should be given significance a little sooner than they have been generally. Certainly this was the observation in the large meeting in Johannesburg in 1969, and this was brought up specifically.

25 But I'm not aware that such a program is in existence anywhere else.

Q. Did you say that...if I heard you correctly...that you don't recall that there was evidence of conflict between the family physician and the chest disease clinic?

A. No, I don't...

30 Q. You don't recall you said that?

A. Conflict between the...



Q. Yes. Conflict between the family physician and the chest disease clinic?

5 A. Sorry, I don't know if I understand you, really.

Q. Okay. I'll say it again. I hope you will bear with me. I went to grade six education, and I'm trying the best I can.

10 Do you recall that where evidence conflicted where the family physician and the chest disease clinic, about a man's health?

15 A. Are you talking of the advisory committee on occupational chest disease?

Q. What I call Grosvenor, the chest disease clinic.

20 A. All right. The family physician does not agree with the diagnosis of the advisory committee?

15 Q. Correct.

A. Yes, I believe that there have been. I believe so. There have been disagreements.

25 Q. I thought you said...maybe I was wrong...but you said there was never a conflict between the family physician and the chest disease clinic?

A. The chest disease clinic, I don't...I have not interpreted as the advisory committee.

Q. Well, that's where you got all the reports, isn't it? From the advisory committee, you call it?

25 A. We get reports from the advisory committee as well as the chest disease service. They are different.

Q. Who is the advisory committee? The same place as Grosvenor, isn't it?

30 A. Yes. The advisory committee meets there, has all its records there and examines its patients there. It happens to be in the same building as the chest disease service, that also keeps its records there.



Q. Is the same people that examined the workers,  
are the same people on the advisory committee?

5 A. Yes, at least two are the same. The other five  
are not.

DR. DUPRE: Let me just run Mr. Cauchi's question  
at you again, given this situation.

10 I have taken that your answer to one of Mr. Cauchi's  
questions was, yes, there has indeed, from time to time, been  
conflict that could be seen between a family physician's report  
on the one hand...

15 THE WITNESS: Right.

DR. DUPRE: ...and what the ACOCD said back to you  
on the other?

20 THE WITNESS: Right.

25 DR. DUPRE: Now, can I ask you this? Insofar as  
when you have a claims file in front of you and indeed may be  
considering whether or not to send it to the ACOCD, insofar as  
that claim file might include something from the family  
physician and some x-rays from the chest disease service, have  
you noticed from time to time that there are conflicts there?

THE WITNESS: Not really, Mr. Commissioner.

Conflicts would most often occur after the diagnosis  
has been, say rejected. But once again, I can't recall in my mind  
specific cases which would fit your example.

25 DR. DUPRE: See, I guess it was this morning in  
your direct testimony, you certainly impressed upon me that you  
attach, when you are looking at the file, a possible forwarding  
to the ACOCD...you attached considerable importance to whatever  
appears in that file that involves x-rays from the chest disease  
service, correct?

30 THE WITNESS: Yes.

DR. DUPRE: Now, I guess what I'm wondering about



DR. DUPRE: (cont'd.) is this - I can well see why, in any of a number of instances, quite possibly the normal thing to do would be not to send something to the ACOCD if what you have in that claims file is an x-ray from the chest disease service attached to the form eight S, that shows almost nothing or nothing.

5 But now supposing you had the same kind of x-ray that shows almost nothing, and yet the family physician may indeed have put in the claim himself, does that situation arise often?

10 THE WITNESS: I think it could arise, and under those circumstances the claims department is entitled to suggest that the claim be seen by the advisory committee.

15 We have a choice, I suppose, of recommending that he should not see, or he should see it. Under those circumstances, if there is a request by the claims department, because of this clear conflict, we would recommend that claim be seen by the advisory committee. We will certainly not dig our heels in as medicals and say, no, just because we think that it probably will not turn out, and as I have tried to say, many do not, obviously, impress the committee.

20 So those claims will go.

So I'm saying if there is a genuine contention and there seems to be insoluble difference of opinion, we will end up by sending it to the committee. If we are not pressed, we will then simply recommend that it not go.

25 The claim department has a role here, and we have often followed their request that it be sent.

MR. CAUCHI: Q. In my years of dealing with the problem, I never seen a man being recalled to be re-examined, which I think is a fair way to do it. If there is a conflict between the examining physician at Grosvenor and his physician, 30 when the report comes to you do you ever ask for the family physician's report?



THE WITNESS: A. No.

Q. You always get the occupational health branch,  
5 right?

A. Not routinely. Once we get the advisory committee's report, the full report, we will...unless something is wrong...we will simply send it through to the claims department for processing. We will not request further information unless there is a request from the advisory committee for some further  
10 action on our part.

DR. DUPRE: I think that Mr. Cauchi, though, in his question was referring to a chest disease service x-ray, as distinct from the ACOCD.

MR. CAUCHI: Oh, yes. The chest disease...

DR. DUPRE: So that...

MR. CAUCHI: That's why I keep referring to the chest clinic at 50 Grosvenor.

DR. DUPRE: The problem there is, you see, that they are all at 50 Grosvenor, so let's keep using the term chest disease clinic, for the moment.

MR. CAUCHI: Chest disease clinic, yes.

DR. DUPRE: If we mean the Ministry of Labour service that...

THE WITNESS: The surveillance program.

MR. CAUCHI: Survey, yes.

DR. DUPRE: That is the surveillance.

THE WITNESS: So, all right. So, I'm sorry.

You wonder whether we have any role to play in that surveillance program, direct role, following the x-ray...as a result of that x-ray?

DR. DUPRE: If the family physician has told the worker that he has a condition that the chest disease surveillance service believes is not there.



5 MR. CAUCHI: If there is a conflict.

THE WITNESS: All right.

If there is a request from the family physician to open a claim, we will open a claim. We are obliged to open a claim.

MR. CAUCHI: Q. But he is never told or asked to submit a report to the chest disease specialist - which is you - so you could report that report back to the ACOCD? Am I correct?

10 THE WITNESS: A. If we receive a request from your physician about your chest, we will open a claim and deal with it in the usual way. We will attempt to find all the evidence and we will pay due attention to the chest surveillance report that we may have on file, or that may be included with your family doctor's report or letter or eight S.

15 Q. The problems start already with the surveillance group. If that doctor that examined the patient or the worker...it won't be a patient then - just a routine examination once a year or once every five years, or whatever...in his report to you states that there is no evidence of an industrial disease, fifteen million specialists could say what they want because you never take their word. Am I correct?

20 A. Well, it's not absolutely correct. If a specialist's report was sent in along with the report from the surveillance program, 50 Grosvenor, and they disagreed with each other, we might feel obliged to send a patient to the advisory committee and let them work out the dispute.

25 Q. Do you ever recall a case where the patient was sent to the advisory committee?

A. Well, under what circumstances? You mean under the circumstances that I have just outlined to you, where...

30 Q. You are talking about the ACOCD or about the other committee?

A. No, the ACOCD.



Q. I never recall of any worker, of any worker,  
during the last twenty-five years...I say thirty years now, since  
5 I been away for six years...that ever, ever appeared in front of  
any ACOCD committee - just the one member, yes, who was recalled  
and they re-examined maybe sometime by the same doctor that says  
there is nothing wrong with you, but not by the ACOCD committee.

A. Oh, hold it. Oh, yes. Okay.

10 The examination of people by the committee is done  
by individual members of the committee, and the case itself is  
presented to the whole committee. But the man himself is not  
there. He has already had his examination and the results of the  
examination are then presented to the committee, the whole committee.

15 So no, he will not be examined by seven people or  
five people.

Q. Why not? What is the idea, what is the idea,  
what kind of sense does it make...Mr. Uffen was saying this  
morning there, if a judge is going to order an inquiry and then  
he is going to hold the inquiry...you know, I am examined by a  
physician at 50 Grosvenor, and he send me a clean bill of health.

20 My doctor look at it and says, what's the matter  
with him, was he half asleep, he is wrong, here is my report, and  
he tells me that I do have the disease. I appeal that case and I  
say I do have something wrong with me.

You say to me, Mr. Cauchi, you better be re-examined.

25 I come back to 50 Grosvenor, and the same guy is  
going to re-examining me? What kind of nonsense is that?

A. Your case will be again presented to the  
committee if you are re-examined, and any changes in your  
status will be taken into consideration.

30 DR. DUPRE: Mr. Cauchi, you are getting full and  
frank answers to your questions, and as far as the impression that  
they are making on the Commission, you can leave that to the



DR. DUPRE: (cont'd.) Commission to do for itself.

MR. CAUCHI: I understand now, Mr. Chairman.

5 MR. EDWARDS: Mr. Chairman, perhaps I could just interrupt here for one second, and get some indication as to how long my friend intends to be, because Dr. Stewart has been on the stand today for quite some time, and I'm sure he is probably tired and might be appreciative of a break.

10 DR. DUPRE: Well, we can do that, or we can consider continuing early tomorrow morning.

What time are we looking at at this point?

15 MR. CAUCHI: Well, I have about five more pages, Mr. Chairman.

THE WITNESS: I'll go on, if you wish.

20 MR. CAUCHI: I could come back tomorrow morning, no problem.

THE WITNESS: I am willing to go.

DR. DUPRE: Miss Jolley?

MISS JOLLEY: I don't have too much.

25 MR. CAUCHI: I could go through these in half an hour, Mr. Chairman, no problem.

DR. DUPRE: Oh, you think...okay. Well, why don't we...

MR. CAUCHI: It's up to Dr. Stewart. If he wants to remain, it's fine.

25 THE WITNESS: No, it's okay. We'll go on.

DR. DUPRE: ...take a break if you wish, and come back about six-fifteen?

THE WITNESS: I would like to carry on.

DR. DUPRE: Okay, fine.

MR. CAUCHI: Okay with you, then?

30 Okay, Mr. Chairman.

MR. CAUCHI: Q. You also mentioned this morning



5 Q. (cont'd.) about the time to assess the workers for a claim. What does it usually take for a worker to be assessed at the place of work? How much time it takes to assess the worker?

THE WITNESS: A. At 50 Grosvenor?

Q. No, at his place of work. Usually all these assessments is done at the place of work - the mobile unit.

A. Oh. Once again, Mr. Cauchi, that's not my area. I don't even know. That's the Ministry of Labour's...

10 Q. I only ask that question because you said usually it takes three to four hours.

A. I'm talking of examination by the advisory committee. Not the...

15 Q. When you send reports about a claim, to the ACOCD, do you ever obtain a dissident report, if there is a dissident report?

A. Do we ever...a dissident report?

Q. Yes.

20 A. A dissident report. No, there is no provision or no...it is not the custom to do so. It has evolved over the years that the committee reaches a consensus and their opinion is then deemed as unanimous. There is no provision. It just hasn't been worked out that way. It hasn't evolved that way.

25 Q. I asked that question because it was stated by Dr. Vingilis that sometimes they could go four to three, and three to two, or two to one, you know, and against the worker. I find that rather odd. If it goes two to one against the worker, why the claims adjudicator don't ask for a dissident report so he could base his 'ineligible' on his form that he send you that your claim is rejected, you know, the benefit of the doubt, your right. That's why I ask this question.

30 Even the Supreme Court of Canada gives you the dissident report.



Q. (cont'd.) If a man is on a ten percent disability, and he dies, according to the guidelines of today his widow is not entitled for any compensation.

A. There are no guidelines associated with death claims.

Q. With death claims?

A. No guidelines.

Q. If he is not on a hundred percent compensation, his widow won't get nothing - his survivor.

A. His widow doesn't automatically get nothing. She may get something, but it's not automatic. Let's put it that way.

Q. It's not automatic - unless there is what you call a tissue report or an autopsy report, correct?

A. No, unless we can be sure that the asbestosis was the principal cause of death.

Q. The cause of death.

A. Principal contributor to death.

Q. I notice that one of the cases that was rejected for survival benefits, the claimant was on a seventy-five percent disabled from asbestosis?

DR. DUPRE: You are referring to the table in...

MR. CAUCHI: Correct.

DR. DUPRE: ...the Barth study here?

MR. CAUCHI: Correct.

THE WITNESS: Where is this? What...

DR. DUPRE: Table one, page three, ten, Dr. Stewart.

THE WITNESS: All right.

DR. DUPRE: The seventy-five percent claim that Mr. Cauchi refers to has intestinal obstruction listed as the cause of death.

MR. CAUCHI: And yet he was receiving seventy-five



MR. CAUCHI: (cont'd.) percent disability pension for his asbestos dust disease.

5 THE WITNESS: A. I can't give you the thinking, the exact thinking, that went into the rejection of the claim, since I don't have the claim in front of me, and it would be very unwise for me to try to speculate - even at that high level of disability - as to why it was rejected.

10 Q. I'm glad to hear you saying speculate.

A. However, I'm speculating because I do not have the file. In order to respond to your question, I really must have the file in front of me to see why and to explain to you why.

15 I don't know what the explanation was. I can only presume that if it was unsatisfactory that the person involved, or the estate, could appeal the claim, and they should have if they were not satisfied. That's their right.

But I just can't intelligently discuss it.

Q. On a seventy-five percent rating?

20 A. No, no. I can't intelligently discuss it because I don't have the claim so that I can get the background to it and get an explanation. There may be something there that will explain it easily.

25 DR. DUPRE: Just so that one thing remains clear to me, Dr. Stewart, you can have a ninety-nine point nine percent rating, if that was theoretically possible. The fact of the matter is that the Statute requires that there be a linkage between the cause of death and the compensable condition, of anything less than a hundred percent. Correct?

THE WITNESS: Yes.

30 MR. CAUCHI: Q. Do you recall how many times the appeal board went against your recommendations for claims, asbestos claims, that is?

THE WITNESS: A. I think I can recall at least once.



Q. Once, eh?

A. There may have been more in the past, over the  
5 years. I just don't know.

I don't know.

Q. What happened to a worker that is assessed at,  
say, thirty percent, but he is given temporary full benefits -  
temporary full benefits....in the meantime, the worker dies?  
Does it say in the Statute there that his widow or his survivor  
10 is going to carry on the...

A. I don't believe that that...

Q. From the autopsy report?

A. First of all, if he had the thirty percent and  
he was given some supplementary benefit to bring him up to a  
hundred percent equivalent, and then he died, this would not  
15 automatically entitle the widow to a pension because his actual  
pensionable award was thirty percent. Then we would have to look  
at the claim based on the circumstances of the case.

Q. The tissue report and the autopsy report?

A. Yes.

20 Q. And if the autopsy report is clear that  
asbestosis was the cause, then the thirty percent doesn't mean  
very much? He would be assessed as totally died from asbestosis?  
Is that what you are telling me?

A. No, we would simply...if we had an autopsy and  
the man died, we would have to see what he died of - quite apart  
25 from the fact that we might...

Q. I said that, doctor. Say the autopsy says  
straight forward asbestosis.

A. Yes.

30 Q. So the thirty percent doesn't mean nothing, his  
widow or his survivor is going to carry on with the full widow's  
pension?



A. No, you cannot deduce impairment from tissue.

The degree of change in the lung tissue is not  
5 synonymous with the impairment. You can't work it out just from  
looking at the autopsy report. Impairment is functionally related  
and only can be measured in life from measurable parameters of  
breathing.

DR. DUPRE: I think the point of Mr. Cauchi's  
question was....

10 THE WITNESS: Maybe I missed it.

DR. DUPRE: ...that the individual has been  
receiving his thirty percent impairment pension, dies, the  
cause of death is indeed asbestosis. Well, then, of course,  
the survivors qualify for the pension.

15 THE WITNESS Oh, of course. Yes.

DR. DUPRE: And I think that you mentioned in answer  
to the questions I asked you earlier, that from time to time you  
have allowed some retroactivity in those cases?

THE WITNESS: Definitely.

20 DR. DUPRE: Because if a man has died of asbestosis,  
he is clearly on the road to a hundred percent.

MR. CAUCHI: I wish I could explain myself like  
you, Mr. Chairman.

DR. DUPRE: Not at all, Mr. Cauchi. You are doing  
very well. Please proceed.

25 MR. CAUCHI: Q. It strikes me where five cases or  
six cases, in the Barth report here, of mesothelioma, claims were  
rejected. As you suggested here, because of nonoccupational  
exposure, am I correct?

THE WITNESS: A. Because of lack of occupational  
exposure documented...

30 Q. That's right. Non...pretty well nonoccupational  
exposure?



A. No, I'm not saying that. I'm saying lack of documented occupational exposure.

5 Q. Lack of exposure. But you also stated that no tissue report was ever asked for.

A. I am saying that in those cases we rejected for mesothelioma, I can't be sure that we went as far as we did with the other claims that had documented exposure.

10 So, you know, I can't give you a precise answer there, because in truth, if there was no exposure it would not be necessary for us to go further and get tissue, because there would be no right established for the claim.

But I couldn't tell you the details of those rejected cases, whether we did or not.

15 Q. In your capacity of chest disease specialist there, was there ever studies taken by the WCB with regard to asbestos workers who have died from other asbestos-related diseases, but were never compensated?

20 Like, now it's compensable for lung cancer and larynx, and stomach cancer. Did the Compensation Board or anybody else ever done studies that some asbestos workers have died from other diseases, such as the ones that were rejected by your people, myocardial, and so on and on?

25 A. My answer to that is that we haven't because we lack autopsy study...one of the reasons that would help us greatly if...that's one of the reasons why I can't answer your question.

Q. One of the questions that was asked to you by the Commission, Dr. Stewart, was about the keeping track of exasbestos workers, and I know it's hard to find them - not only for you people, but also for unions, but we try to - but it strike me odd that some people are recognized as asbestosis when they are overseas. They come to this country, they say there is no evidence of chest disease condition. Yet the same man...I'm



Q. (cont'd.) referring to a specific man now, you don't have to answer that...was picked up at a Canadian embassy 5 when he wanted to emigrate to Canada, reemigrate to Canada.

They ask him, did you ever work in an asbestos plant? He said, yes.

He was permitted to re-enter Canada just because he had that type of disease. Yet when he comes to this country 10 to get his claim established, he is assessed ten percent.

I find it very odd. I just thought I would mention 10 that.

We'll go to that special rehabilitation program, which you were part of the team. If you recall, I was on the other side, which you and Mr. Larry Carr and Mr. Charlie Coats and Mr. 15 Boyd, were the whole team, and I was representing the union at that time.

Do you recall the initial program was not to relocate people from one corner of the plant to the other corner of the plant? The initial program was...am I correct that you had a list of one hundred and sixty men, some of them were salaried employees, and a hundred and sixty men were suffering from some 20 type of an asbestos dust effect and they were eligible...all eligible, I should say, to go on the program. Am I correct?

A. No. I met with the company, the union and our own representatives, in June of 1976, and I clearly stated to them then that those that would be eligible, we would not know 25 until we had finished our dust counts of the plant.

I did state at that time also that we could presume that those who worked in the fiber glass area would not be eligible, and that's as far as it went.

In subsequent interviews with individuals, it 30 was stressed to them that we did not know precisely what would happen, and that they may or may not be qualified for the program.



5 A. (cont'd.) It was only in June...in February/March of 1977, that the actual division in the plant was decided on. Transite pipe qualified, all others didn't qualify, and that was made very clear to the union president and to the company, in June of 1976.

Q. The union president wasn't even there at that time.

10 A. Yes, he was. There was full union representation in this meeting with the company in...

Q. It was in 1976 when the first...

15 A. I am telling you of a meeting we had, and I have the minutes of it, and I submitted it to my superiors.

Q. So do I, but I'm talking about the initial program that was told when you brought the list to us. You never brought the list to the company, if you recall, and they were pretty upset.

A. Sure they were upset.

20 Q. I saw no objection in giving them the list, because there was some salaried personnel...as a matter of fact, is it true that one of the first men that took the rehabilitation program never even did work at the transite pipe department?

A. Oh, I don't know. I can't remember. Honestly, I can't remember.

Q. I know that.

25 A. I just can't remember. All I know is that no commitments were made to any person until the dust counts were settled and the...

Q. And that was when?

A. Early 1977.

30 Q. Well how come some of the men have been out since 1976?

A. I can't recall. I think that the actual...the



5 A. (cont'd.) individuals that went out would...  
that would have to be answered by the rehabilitation department  
of our Board.

Q. Well, I mention that to you because you were  
saying people that were eligible for program had to be in  
a dangerous area. Correct?

A. They had to be...

Q. And later on, at a later date...

10 A. ...working in transite pipe.

Q. ...it's correct, it was established that unless  
you work in a dangerous area you are not entitled to go in the  
program.

A. Yes.

15 Q. And the first initial stage, the first meeting  
in June of 1976, when we met in the board room with Mr. Machin,  
he stormed out of the room because there was no list of employees  
for him and we suggested to you people that we have no objection  
to give him the list. And a problem on the program was that if  
20 a man is suffering from some type of any asbestos dust inhalation,  
well that person is eligible - whether you worked in the kitchen  
or the washroom.

In fact, the first man that took on the program,  
and he is still on the program, never even worked in transite  
pipe department.

25 A. I am aware of two or three, possibly a maximum  
of four people, who did get on the program through an error of  
communication on our part - commitments made by one of our people,  
probably through misunderstanding of a conversation with me,  
so there were two or three people, maybe four, who got in the program  
who would not normally be eligible.

30 That I do recall, and I freely admit.

But what I do say is, we were not prepared after



5 A. (cont'd.) that to keep on with the error, and I think we settled that business and we got our communications straight within our own team.

Q. On what basis, Dr. Stewart, they won't be eligible? Can you explain, please?

10 A. I tried to explain that today in detail, as to the thinking that went behind my choice and my recommendation to the Board of areas that were considered reasonable to work in, for people who had been affected.

I went into detail and was...

DR. DUPRE: That has been well covered, Mr. Cauchi.

MR. CAUCHI: Okay.

I think I've had enough. Thanks very much.

15 DR. DUPRE: Thank you.

Miss Jolley?

MISS JOLLEY: I just have a very few questions.

#### CROSS-EXAMINATION BY MISS JOLLEY

20 Q. The first one is again about the ACOCD, and every claim that is submitted to them through you or Dr. Dyer, do they examine every single claim? Do they spend three to four hours with every single person you refer?

25 A. As far as I know ...whether it's three or four hours, whether...it could be, yes. But yes, as far as I know, that's true.

Q. If a worker has just been through the chest disease section of the Ministry of Labour and has gone through the testing there, and then the claim is referred and it's referred back to the advisory committee, is there a possibility, if it is the same physician, that they might not re-examine the person?

A. No, no. He is always re-examined.



Q. Can I move on to mesothelioma, and one of the things that you said to Mr. Cauchi when you were referring is that 5 the ACOCD always asks the man about the exposure to which he was... or maybe not always, but that they explore that with the claimant.

A. I believe they always do. They always do, because...well, I can't imagine them not.

Q. However, when a cancer claim comes to you that 10 has only the company dust records...

A. I'm sorry. Did you say mesothelioma? Are you talking of that?

Q. Well, first of all I am now talking about mesothelioma. I was talking about asbestosis with the advisory council.

15 A. Okay, fine. All right.

Q. When a mesothelioma claim now comes to you, that is not referred to the advisory council, but comes to you and the company's submission on the form S seven suggests that in fact there was no exposure, do you pursue that...

20 A. We would not accept one single report. Most people, unless they have worked for a company like Johns-Manville, have worked for many companies - are likely to. And we never assume there is only one company involved.

25 Therefore, we will certainly clarify that in an attempt to obtain the entire exposure. We will not leave it at that.

In fact, if a man has mesothelioma we will automatically assume there has been occupational exposure unless it is otherwise shown - unless we cannot get confirmation of it from anywhere.

30 Q. So if you are assuming that there is occupational exposure, where do the guidelines come in for mesothelioma recognition? Where does that ten years of continuous or repetitive exposure come in? Who makes...



A. Well, we will attempt to establish the duration of exposure if we can, but as I said, if it's occupational and if it's almost just months, we will accept it. We will not insist on ten year, the ten year provision.

5 Q. These guidelines, it has been suggested by Professor Barth, are continually revised and reviewed and I wonder why, if that's your practice, don't you alter your guidelines.

A. Well, put it this way: We developed the 10 guidelines based...we tried to develop the guidelines based on current conditions. This is one of our...went into our thinking in our approach to lung cancer and mesothelioma...that under today's current conditions, mostly...and the use of asbestos has gone down, and in many cases the exposure is much less...that we would expect today, under today's conditions, that ten years 15 would be a reasonable minimum.

Q. But you are not compensating for today's exposures.

A. But we are including that claim under the third provision of our guidelines. But we wish to retain the 20 ten years as a reasonable minimum for today's conditions. But we end up by accepting virtually them all.

DR. DUPRE: This has been basically...I think I am repeating a question that I have asked earlier, but I want to make sure that I got it straight the first go around.

25 When all is said and done, a guideline sets up a close-to-irrebuttable presumption in favor of the case, administrative case.

THE WITNESS: Yes.

DR. DUPRE: And...

THE WITNESS: The majority of them.

30 DR. DUPRE: ...given that it does that, you hardly need spend more than two seconds on it once you have simply got the diagnosis confirmed and you know the amount of time.



DR. DUPRE: (cont'd.) Now, a case that falls outside of the guideline, does not have what is virtually an administratively irrebuttable presumption and therefore will be analyzed, but as you say, and as the Barth record shows, almost inevitably will wind up being granted...provided always that there has been occupational exposure.

THE WITNESS: Yes, that's fair enough.

MISS JOLLEY: Q. Well in fact some of the stomach cancer claims have...they have perhaps not followed the guidelines right down to the line, but there have been cases rejected on the exposure guidelines.

THE WITNESS: A. Yes. We look on mesothelioma as much different than stomach cancers, and in mesothelioma we do not assume a dose response. We don't fall back on a dose-response requirement, whereas in stomach cancer we look for it. We feel that the minimums there are fairly reasonable based on the studies. It's arguable, but that's the way we feel.

So that's why there are a fair number of stomach cancers rejected, based on the guidelines, on the requirements.

Q. The laryngeal cancer guideline, when you referred...I know not perhaps you personally, but when it was referred to Dr. Miller to carry out his study after the Selikoff material and after Dr. Ritchie reported, did you refer nickel to him as well, to consider?

A. Yes.

Q. You did?

A. Yes, nickel was included in the case/control study that Dr. Miller started - the first, which was in two phases. The first phase which he opined on the results of sixty-three-odd cases, and in the second phase, his concluding phase, in which he had over two hundred or a hundred and fifty cases, and he made his final report. We acted on that interim phase report as far as



A. (cont'd.) laryngeal cancer is concerned, and that's why we included in those guidelines both asbestos and nickel.

5 The final report, however, was somewhat different, and he failed to sustain his first impression that nickel was...

Q. Oh, really?

A. Yes. But he supported his first impression on asbestos.

10 Q. So his final report is finished and has been submitted to the Board?

A. It's my awareness that it is finished. I do not know if it has been published, officially published in a journal.

Q. Just very briefly, have you had any claims for kidney cancer submitted to your...to the Board?

15 A. In asbestos workers?

Q. Mmm-hmm.

A. Not to my knowledge.

20 Q. The pancreatic cancer that you mentioned this morning that ultimately was resolved out as a mesothelioma, at least a decision came down in favor of the worker in that one, was it rejected initially because it was pancreatic, or...?

A. It was rejected because of the pathologist's, our own pathologist's opinion that it was a pancreatic cancer.

Q. Originally. So it did go to Professor Ritchie initially?

25 A. Yes.

Q. It wasn't rejected out of hand as a pancreatic?

A. No. It was based largely on his report.

30 Q. If you received a kidney cancer case at the present time, would you reject it because it's not a recognized cancer related to asbestos, or would you again submit it as a potential misdiagnosis?

A. No. If a diagnosis was proven, in an asbestos



A. (cont'd.) worker...

5 Q. If the pathologist at a hospital submitted a report to you that suggested that it was kidney cancer that was the cause of the death, would you then ask for tissue and send that to Dr. Ritchie for further confirmation of the diagnosis?

10 A. Well, we might not, because up to now kidney cancer is not being considered as a legitimate asbestos-induced disease, so we might not follow it up.

15 Q. However, Dr. Ritchie yesterday did say that kidney cancer was one of the other diseases that was most often diagnosed for mesothelioma.

20 A. I see what you mean. Okay, I understand your point now.

25 Q. I guess I'm concerned about misdiagnosis.

A. I understand your point.

I think that it would be very unusual for kidney cancer spread in the abdomen to act like a mesothelioma, but if there was any doubt, yes, we would definitely try to resolve it.

20 Q. The letter that Dr. Selikoff sent to Dr. McCracken in 1977, where he submitted to the Board the original material about laryngeal cancer, in fact draws a conclusion that he found a statistically significant increase in kidney cancer.

25 A. I know. We are not sure, however, of the diagnosis.

In my three days at the international symposium in Montreal, not once did I hear kidney cancer mentioned as a possible asbestos-induced disease.

Q. But did you pursue that as a...when you received that letter, what did you do with that information?

30 A. We would find that...well, we did not conclude that we should seriously consider it at that time, that it was a little early, the association was not strong, and that we had not



5 A. (cont'd.) seen any confirmation of it from other studies in the literature. And we would take that attitude today, that we would like to see other studies in which there's more cases involved - far more cases.

When you get down that low in the number of cases, it's really...you have to look with some suspicion on the strength of the association involved.

10 I mean, we require more than that to consider a case, to consider a disease compensable. It just isn't scientifically enough for us, and certainly our executive director wouldn't entertain it in that sense. In my view, he would require more of... we would like to see more.

15 Q. Do you regularly review the world literature on the various...

A. We try to, let's say we try to follow it up. We try to keep up with it. If that's what you mean by review.

Q. Mmm-hmm.

A. You don't regularly review it sort of...

Q. So you would be watching for...

20 A. We try to watch it.

Q. ...new material coming out that might also repeat Dr. Selikoff's findings, or...

A. Yes.

25 Q. Perhaps for the lymphomas as well, that have shown up in...

A. People might bring this to our attention, too. It's not just ourselves. We may well receive a recommendation from someone else.

30 Q. Can I go off onto an entirely different subject now, and this is the subject of the new asbestos regulation.

A. Excuse me. The...?

Q. The new asbestos regulation proposal from the



Q. (cont'd.) Ministry of Labour?

A. I'm not sure I'm expert on that.

5 Q. Well, you managed to be quite outspoken at the public meeting about the aspect I'm going to discuss with you.

Was the Board consulted about the whole surveillance program and the removal of workers from, the potential removal of unfit workers?

A. Are you...what meeting are you referring to?

10 I'm curious to know.

Q. It's the public meeting on the asbestos standard, back last September, that the Ministry of Labour had.

A. Oh, oh, oh. I had forgotten that.

What did I...

Q. I'm just going on to pursue it.

15 A. Right. Okay.

Q. Was the Workmen's Compensation Board consulted over the whole surveillance program that the Ministry of Labour is now putting into private hands, as you said before, earlier today? Were you consulted as to some of the problems that might occur about physicians determining fitness?

20 A. Yes, we have had input. We were allowed input and we have submitted over the years, the last three or four years, our opinions regarding surveillance. Yes, we've had our input in that.

Q. I think the concern, and it might be a concern 25 that you could address, that I have, is that if a physician with an asbestos company or an insulation company, or whatever, determines that the worker is no longer fit to work with asbestos, and he suggests to the employer, as it is laid out in the regulation, that this worker should be removed from future exposure to asbestos, and there is an automatic provision in that regulation that compensation 30 will be given to make up either the difference or to provide,



Q. (cont'd.) wherever there is a wage loss, and I think the concern I have is that, are we going to hit conflicts of physicians determining fitness in this privatization format, as you have described, and where the Board is going to start rejecting those claims?

A. All right. Now I know what you are talking about.

I believe that there is a provision in the regulations that specifically restricts that ability to take a man out only when it's referred to the Ministry of Labour or the Compensation Board. We were concerned about that, and we have advised them that we may well not agree with the physician's act in bringing the man out. He may end up with no compensation.

So I believe the provisions are in the Act now, that specifically refers that right to the Compensation Board. The doctor is alerted to that now.

DR. DUPRE: The doctor is alerted to what, again?

THE WITNESS: The Act gives the...seemingly gives the private physician the right to take a man out if he feels that the man has a condition that is related to the work.

DR. DUPRE: You mean the Act, or do you mean the proposed asbestos regulation?

THE WITNESS: I'm sorry. The regulation.

DR. DUPRE: Okay.

THE WITNESS: So it seems to say that anybody can take his man out when he wants, but another...farther down the line it is stated specifically that...it's clarified that this must be done in association with, consultation with the Workmen's Compensation Board.

So I think it's clarified.

MISS JOLLEY: Q. We just haven't...I haven't personally seen the new asbestos proposal, so I have no idea.



THE WITNESS: A. I think you will see that there.

Q. Yes. It was not in the September meeting, and  
5 that's why you raised it at that meeting.

A. Yes.

Q. I just wanted to pursue that.

A. Yes, I remember that.

Q. The final question I have, and that's a question  
10 that you have been asked before, and that is, when the claims come  
in to the Workmen's Compensation Board, as they start to build up  
from certain companies, what sort of connection do you have with  
the Ministry of Labour to alert them to the disease that is  
occurring?

A. Are you talking of any claims, or of asbestos?

15 Q. I'm talking about when you start to receive  
asbestosis claims or cancer claims from a particular company, I  
mean a cluster of claims - two, three, four for the same thing -  
what kind of relationship do you have to the Ministry of Labour  
that alerts them to the fact that you are seeing...

20 A. We have an arrangement whereby all our  
claims are reported to the Ministry of Labour, and we frequently  
met with them on this to try to make sure that we are not  
missing things, that they are not missing trends. But I think  
that in that case that you illustrate, if it's that obvious it  
25 wouldn't have to be made clear to the Ministry of Labour in that  
route, that we would have a meeting on it or we would arrange our  
own meeting and we would discuss it that way.

We wouldn't have to let them find out for themselves  
by examining our records that we send over. Hopefully we would have  
spotted the trend and we will advise them, and not they advise us.

30 But generally we have a workable system whereby  
new claims involving industrial disease, that appear, are made  
known to the occupational health branch - particularly since



A. (cont'd.) they then can go into the workplace.  
Yes, we have been working on that. We feel it's  
5 important that our discoveries are made known to the occupational  
health branch.

MISS JOLLEY: That's all I have. Thank you very  
much.

DR. DUPRE: Thank you, Miss Jolley.

I have no questions, Dr. Stewart, so may I, on behalf  
10 of the Commission, thank you most warmly for this long, gruelling  
day that you passed, for you, but one that has been a most  
educational day for us.

Thank you, indeed, sir.

Now, Miss Kahn, you wish me to say that we rise  
until nine a.m. tomorrow morning?

15 MISS KAHN: Yes, when Dr. Cameron Gray will be  
joining us.

DR. DUPRE: When Dr. Cameron Gray will be joining  
us. Thank you.

We rise until nine o'clock tomorrow morning.

20 -----

THE INQUIRY ADJOURNED

25 THE FOREGOING WAS PREPARED  
FROM THE TAPED RECORDINGS  
OF THE INQUIRY PROCEEDINGS

30 Edwina Macht  
EDWINA MACHT





